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NURSING HOME CARE: THE UNFINISHED AGENDA
(Volume I)

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

WASHINGTON, DC

MAY 21, 1986

Serial No. 99-19

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NURSING HOME CARE: THE UNFINISHED AGENDA

WEDNESDAY, MAY 21, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee convened, pursuant to notice, at 9:10 a.m., in room SD-628, Dirksen Senate Office Building, Hon. John Heinz (chairman) presiding.

Present: Senators Heinz, Glenn, Pryor, Chiles, Cohen, Grassley, Pressler, Bingaman, Nickles, and Wilson.

Staff present: Stephen McConnell, staff director; Robin Kropf, chief clerk; Isabelle Claxton, communications director; Sara White, assistant communications director; Jim Michie, chief investigator; David Schulke, investigator; David Cunningham, investigator; Diane Lifsey, minority staff director; Bill Benson, minority professional staff member; Kimberly Kasberg, hearing clerk; Diane Linskey, staff assistant; and Dan Tuite, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ

Chairman HEINZ. Ladies and gentlemen, the committee will come to order.

Good morning. It was about 12 years ago that this committee, the Special Committee on Aging, released a report of its investigation into nursing home care in the United States. The conclusions of that report were quite alarming, with over 50 percent of the homes in the country cited for abuses ranging from untrained or inadequate staff, negligence leading to death or injury, lack of control of drugs, unsanitary conditions, and poor food.

Today the committee is releasing a second report, which I have here and which has been provided, I think, to all the members of the press, with the findings of a 2-year staff investigation of the current status of care in the Nation's some 15,000 federally certified nursing homes.

Frankly, the news, after all these years, is still grim.

Now, to be fair, some homes do provide quality care. Many homes provide adequate care. Indeed, take the two together, quality care and adequate care, maybe as many as two-thirds of the nursing homes in this country provide either adequate or quality care. But for a substantial number of homes which we have looked at, what we have seen is that we have allowed bed, board, and abuse to replace the medical and rehabilitative care that the law demands.

We have warehoused tens of thousands of our oldest, sickest citizens, and the Federal Government is not doing anything about it.

Facilities participating under the Medicare and Medicaid Programs must comply under the law with certain conditions of participation and undergo annual inspections to prove that they continue to, quote, "substantially," unquote, meet these conditions.

Now, there is always argument about what conditions are important and which ones are unimportant. Well, the Aging Committee staff analyzed inspection reports for some 8,852 skilled nursing facilities for the years 1982 to 1985. We have over 1,100 feet of computer printouts of violations—more than 200 feet a year. And we were only evaluating performance—and this is the most important point—on the 25 most critical conditions out of some 541—just the 25 most important out of 541.

Our data shows that more than one-third of these facilities, about 3,000, failed to meet at least 1 of those 25 basic conditions—25 of the most important of the 541—in 1984. Over 1,000 homes failed to meet three or more such conditions. A substantial number of these homes, around 600 of them, are not only grossly inadequate, but they are chronic offenders, violating not only three or more conditions, but doing so at least three out of four inspections.

Most indicative of the backslide in quality care in nursing homes today are the dramatic percentage increases in the number of violations of the most critical life-sustaining conditions.

This chart here shows nine critical components of critical standards. We found a 75-percent increase in citations for lack of adequate physician supervision. That is No. 4 there. It went from 73 to 128, a 75-percent increase. We found a 61-percent increase in facilities failing to provide adequate 24-hour nursing care, and this is in a skilled nursing facility.

And dropping down just two more, we found a 92-percent increase in the failure of facilities to meet patients' nutrition and feeding needs; and a 75-percent increase, going up to the third from the top, a 75-percent increase in patients subjected to mental, physical, and/or chemical—that is to say, drug—abuse.

Now, we may have brought buildings up to code. We may have brought about daily cleaning of the hallways. We may have drinking fountains now up to regulation height. But we have at this point failed, I think somewhat dismally, to assure a decent level of patient care.

Recent reports from the Inspector General of the Department of Health and Human Services and by the Institute of Medicine reinforce the findings of this committee. In testimony submitted for this hearing, the Inspector General of the Department of Health and Human Services states that—and I quote, "Failure of nursing homes to meet Federal conditions of participation are not uncommon," unquote. He goes on to say, quote, that, "Substandard homes can remain in the [Medicare and Medicaid] Programs for years, while providing less than adequate care to patients."

And the Institute of Medicine's report finds that 10 to 15 percent of homes with chronic problems remain in the program, if you will, yo-yoing back and forth, in and out of compliance.

These studies and their statistics cannot begin to paint a full picture of endless hours spent strapped in a wheelchair, on a diet of tranquilizers. They do not help the patient whose heart fails in the early hours with no nurse or doctor on call to restore life. But they do—they do—send a clear message to Congress and this administration that we must act and strengthen inspections, enforce penalties, and put the care of the patients first before another year goes by, let alone another 12 years.

We have a very full panel of witnesses today, and I look forward to their testimony, but first I want to call on our ranking member of this committee, Senator John Glenn.

STATEMENT BY SENATOR JOHN GLENN

Senator **Glenn**. Thank you, Mr. Chairman.

Let me start out by saying that it gives me very little pleasure to participate in this hearing today to examine the ongoing quality of care problems in our Nation's nursing homes.

The Aging Committee has a lengthy history of recommending legislative, regulatory, and administrative reforms to ensure adequate care for older Americans who reside in nursing homes.

Many of our recommendations have in fact become law. That is encouraging. But the discouraging part is that, too often, the laws we pass on this issue are not carried out. That is why it is necessary for us to be here once again today addressing these things. Many of the laws have not been carried out, and we are here addressing the "unfinished agenda." Too many of our reforms merely sit on the books. This was the case in past administrations; it was the case in the Carter administration, and unfortunately it is the case, in the Reagan administration, I believe, to an even greater degree. In fact, opposition to the Reagan administration's actions led to a study by the Institute of Medicine, published this past February, which concludes that there is a clear need for a stronger and improved Federal role in the regulation of nursing home care.

It is unfortunate that the Secretary of the Department of Health and Human Services, Dr. Otis Bowen, did not accept our invitation to appear at today's hearing. I was eager to hear Dr. Bowen's thoughts on how we can improve conditions, correct abuses, and improve the effectiveness of Federal enforcement and oversight—and on how we can even just carry out existing law, where we have had law on the books for several years and do not even have the regulations yet to carry them out. In some cases, several years have passed without putting the regulations on the books. The regulations that we wanted written would be out there and in effect.

I am very hopeful that Dr. William Roper, Administrator of the Health Care Financing Administration, who is here, will help end the inordinate delays in implementing the laws that we pass—such as those dealing with the intermediate sanction, authorized by Congress in 1980; the protection of patient funds, based on the 1977 Medicare and Medicaid antifraud and abuse amendments; and the issuance of a list of services telling us exactly what we are buying in nursing homes with Federal Medicaid dollars.

Dr. Roper has been on the job just a couple of weeks, so he is new, and this I believe is his first hearing—is that correct, Doctor?

Dr. **Roper**. Yes, sir.

Senator **Glenn**. We welcome you here, and we are sorry to put you on the pan this morning, but that is the nature of the job that you are in.

While many nursing homes across the Nation, as the chairman said, meet the Federal standards and provide good, tender, loving care, the kind of care you want for any one of your own relatives who may go into one of these homes, far too many fail to meet minimum Federal requirements essential to the health, safety, and welfare of their patients.

I had a personal experience with this within the past 60 days, when a member of my family who was in the hospital, and then had to go into a nursing home in another city—not in Ohio, I would add, and I will not say the city. I went to—I think it was six—different nursing homes to see the conditions that I wanted the family member to have when they got out of the hospital. I was rather appalled. The nursing homes I went into in that major city ran the whole gamut, from absolutely disgusting to excellent, to wonderful. Fortunately, we were able to get my family member into one of those better-type homes. But I would not have wanted to see the person in at least a couple of those places that I visited that day.

I look forward to today's testimony about the actions that must be taken to improve access to quality care—actions such as considering expansion of "swing-beds" prohibiting discrimination against patients who must rely on Medicaid or who are considered "heavy care," strengthening Federal patients' rights and the Nation's system of nursing home ombudsmen, and improving the Federal enforcement system.

My home State of Ohio has adopted a number of important initiatives, including a tough anti-Medicaid-discrimination statute, a patient-oriented reimbursement system, and a strong patients' rights law. And some of the other States have taken initiatives on their own, also not willing to wait while the Federal Government got moving in this area. I am certain that the Federal Government could benefit from studying these and other State-level accomplishments around our country.

Mr. Chairman, I share your concern about the continued failure of the Federal regulatory system to ensure good care and respect for the rights of nursing home patients. These tax dollars used in this way come from all of us, all over this country, and we expect those dollars to be administered to do the job for the intended purpose.

I look forward to continuing to work together to pursue needed legislative and administrative changes on behalf of our Nation's more than 1 million older Americans who live in nursing homes.

Mr. Chairman, that is an abbreviated version of a lengthier opening statement that I would ask unanimous consent be included in the record.

Chairman **Heinz**. Senator Glenn, without objection your entire statement will appear in the record.

[The prepared statement of Senator Glenn follows:]

STATEMENT OF SENATOR JOHN GLENN
AT A HEARING BEFORE THE
U.S. SENATE SPECIAL COMMITTEE ON AGING
"NURSING HOME CARE: THE UNFINISHED AGENDA"
MAY 21, 1986

Mr. Chairman, as the Ranking Democratic Member of the Senate Special Committee on Aging, I must state that it gives me little pleasure to participate in this hearing to examine the on-going quality of care problems in our nation's nursing homes. Like you, I am concerned about the continued failure of the federal regulatory system to ensure good care and respect for the rights of nursing home patients.

It is important to state that there are many nursing homes across the nation that consistently meet federal standards and provide decent care to their elderly and disabled patients. Others exceed these standards and provide exemplary care and services to their residents. Yet, as today's testimony and the written hearing record will clearly demonstrate, far too many nursing homes continue to fail to meet minimum federal requirements essential to the health, safety and welfare of their patients. These facilities, despite the identification of serious deficiencies by federal and state inspectors, continue to receive federal funds from the Medicaid and Medicare programs, while providing inadequate care.

As Members of the Senate Special Committee on Aging, we can take pride in the Committee's track record in identifying serious quality of care problems associated with nursing homes. We have a long-standing record of bringing to light major policy concerns and recommending legislative, regulatory and administrative reforms to ensure an adequate level of care and respect for the rights and dignity of frail, ill and vulnerable older Americans who reside in nursing homes.

The Aging Committee set the pace for protecting nursing home patients with its 1974 landmark hearings and series of reports entitled "Nursing Home Care in the United States: Failure in Public Policy." Some twenty months ago, in October 1984, we conducted an in-depth hearing on "Discrimination Against the Poor and Disabled in Nursing Homes." Many of the issues raised then are with us today. Most recently, we held a series of hearings addressing quality of care issues associated with Medicare's Prospective Payment System (PPS) and learned of serious access and quality problems pertaining to nursing home care. At those hearings, we put forward a number of major recommendations designed to improve quality and access to care, including S. 2331, the "Medicare Quality Protection Act of 1986."

A number of our recommendations have become law and are now on the books. And that's why we are here today addressing the "unfinished agenda" -- it appears that too many of our reforms merely sit on the books. Too often, the Administration has failed to carry out the laws we pass on this issue. These problems, however, are not unique to the Reagan Administration. Protection of nursing home residents is not a partisan issue. Several Administrations have been castigated by this Committee over their failure to protect both patients and taxpayers. Today, we will hear about Smith v. Heckler -- the most important nursing home litigation to date -- originally filed in 1975 by a group of Colorado nursing home patients. Nearly ten years later, after a decade of little action by successive Administrations, the 10th Circuit Court of Appeals ruled, in a landmark decision, that the federal government has a duty to ensure "high-quality medical care."

Unfortunately, this Administration seems determined to turn its back on elderly nursing home patients to a degree that we have never before encountered. The Reagan Administration has repeatedly expressed its intent to reduce the federal role in protecting patients in federally-financed nursing homes. Hopefully, the ruling of the 10th Circuit Court will help to reverse this trend.

At the close of the Carter Administration, the Department of Health and Human Services issued a new rule elevating patients' rights to a Medicare and Medicaid Condition of Participation. The Reagan Administration revoked it within days of assuming office and then proposed to effectively deregulate the nursing home industry in 1982. Consumer and public opposition was so great that this proposal was scrapped, only to be followed by a proposal to reduce the federal role in oversight of nursing homes. Tremendous Congressional and consumer opposition resulted in a Health Care Financing Administration (HCFA)-financed study by the Institute of Medicine (IOM). The final report, issued this past February, concludes that there is a clear need for a stronger and improved federal role in the regulation of nursing home care.

I am pleased that our hearing follows the IoM report and its constructive recommendations, many of which this Committee has previously endorsed. I am optimistic that action will be taken due to Congressional, consumer and public awareness. Public concern, coupled with the work of our Committee and many Members of Congress, the growing network of nursing home ombudsmen, the IoM report and other activities have ensured considerable momentum to bring about needed reforms. An important addition to this momentum is the responsible reaction from leaders in the nursing home industry who have endorsed the IoM report.

Now, it is time for the Administration to join us in our effort. I regret that the Secretary of the Department of Health and Human Services, Dr. Otis Bowen, did not accept the invitation to appear at today's hearing. I looked forward to hearing Dr. Bowen's thoughts on how we can improve conditions, correct abuses and improve the effectiveness of the federal enforcement and oversight responsibilities, and his agenda for resolving the problems that will be raised today.

I am anxious to move beyond the inordinate delays that we have experienced in getting HCFA to implement the laws that we pass. I hope that Dr. William Roper, the newly appointed Administrator of HCFA, will assure us of a new responsiveness at HCFA. As an example, I hope that HCFA will soon issue final regulations for implementing the intermediate sanction which Congress authorized in 1980. Our staff met with HCFA three times regarding the draft regulations issued in February 1985 to make substantive recommendations for improving them. They are important and need to be finalized promptly. Mr. Chairman, you and I wrote to the Administration asking them to promulgate rules regarding the protection of patient funds, which OMB had quashed despite our enactment of the 1977 Medicare and Medicaid Anti-Fraud and Abuse Amendments. That same law requires the Secretary to issue a list of services covered by Medicaid. Despite our efforts, that list has never been published. We still do not know exactly what we are buying in nursing homes with federal Medicaid dollars.

Today's other witnesses, including family members who will share with us their personal experiences with the shortcomings of the nursing home regulatory system, will provide us with an even clearer picture of the inadequacies that must be overcome. This hearing will demonstrate the need to examine the artificial distinctions in our levels of care, and the need to improve access to quality care -- by considering expansion of "swing-beds" and by prohibiting discrimination against patients who must rely on Medicaid or who are considered "heavy care." We will also discuss strengthening federal patients' rights and the nation's system of nursing home ombudsmen; improving the federal enforcement system; and giving states adequate support, including a range of alternative sanctions, to carry out their federally-mandated responsibilities. Finally, as testimony today will indicate, HCFA must effectively gather, analyze and put to use the data it has at its disposal to identify and deal with chronically substandard homes.

Many states have successfully implemented significant reforms to address nursing home problems. The federal government can learn from these efforts and adapt them to ensure that all Medicare and Medicaid beneficiaries benefit from similar protections. My home state of Ohio has adopted a number of important initiatives, including a tough anti-Medicaid discrimination statute, a patient-oriented reimbursement system and a strong patients' rights law. I am certain that HCFA could benefit from studying these and other state-level accomplishments.

Mr. Chairman, I look forward to joining you and other members of the Committee in pursuing needed legislative and administrative changes on behalf of the nation's more than one million older Americans who live in nursing homes, as well as the millions of taxpayers who pay to ensure adequate care and quality.

I appreciate the participation of today's witnesses. What each of you has to say will not only help to increase public awareness about these issues, but will assist us in pursuing legislative and administrative remedies to these very serious problems. I welcome your comments today and the discussion that will follow.

-30-

Chairman HEINZ. Let me just say for the record that this committee does follow the "early bird" rule, except for the chairman, and the next Senator I will recognize under that rule is Senator Pryor of Arkansas who, I have to say, was working on nursing homes back when he was a House Member in 1970 and 1971. He became famous for holding a cookout at a local abandoned gas station because there was no room for the House Select Committee on Aging, which he tried to form. And he even went up to Honesdale, PA, on one occasion, in fact, in those dark days, and he has been a real crusader and pioneer in this area.

David, I imagine you feel a little bit like Senator Glenn, which is that revisiting this issue gives you no pleasure.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Senator GLENN. Excuse me, Mr. Chairman. If I could just have 5 seconds, I have some other commitments this morning, and I will be in and out during the hearing; but I will be reading all the testimony and may want to submit additional questions when it is over.

Chairman HEINZ. Without objection, Senator Glenn.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman, and I appreciate those very kind remarks.

I have a longer statement I would like to submit for the record, and I will just use two or three thoughts at this time.

Chairman HEINZ. Without objection, so ordered.

STATEMENT BY SENATOR DAVID PRYOR

Senator PRYOR. I would like to first say, Mr. Chairman and my colleagues, that this is not a very happy day. This is in fact a very depressing moment, I think, for our country.

We look at the number of violations that we see growing at a very rapid rate, and I must be honest with you, until the last several days I had been led to believe as most Americans that things were getting much better and not getting worse. But it appears that we are not going uphill, we are going downhill. And it is for that reason that I am extremely concerned, and I must say extremely depressed about it.

We see all of these violations, and it appears that the increases in these violations are growing at a very rapid rate. I think that we face a dilemma in our country. What do we do, what sanctions do we impose? I think that is one of the things that this committee must consider. I think that is one thing that we have to recommend.

We know for a fact that over 1.5 million American citizens now reside in nursing homes. That number is going to double over the next several years. And the dilemma as to sanctions and how we police this industry—and it is an industry—that dilemma is going to become even greater and more important.

Mr. Chairman, I am very proud that you have had this study commissioned, and once again I look forward to trying to find some solutions, because I think all of us care, and I think all of us are going to be seeking an answer.

I would at this time like to ask unanimous consent that my statement be submitted for the record.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Pryor, without objection, so ordered.

[The prepared statement of Senator Pryor follows:]

OPENING STATEMENT
SENATOR DAVID PRYOR
before the
U.S. SENATE SPECIAL COMMITTEE ON AGING
at a hearing on
NURSING HOME CARE: THE UNFINISHED AGENDA

9 a.m., Room 628 Wednesday
Dirksen Senate Building May 21, 1986

Mr. Chairman, I am pleased to be here today as the Special Committee on Aging continues its inquiry into nursing home care in the United States. This Committee has had a long-standing interest in the issue of quality care for nursing home residents, dating back to the days when Senator Frank Moss and Val Halamandaris performed their very valuable investigations into nursing home care throughout the country. My own personal interest in this issue began almost two decades ago during my tenure in the House of Representatives, shortly after the establishment of the Medicare and Medicaid programs. I might add that this interest was spurred by the concerns of one of my most vocal constituents, my mother.

Only 1.4 million senior citizens reside in long term care institutions in this country (about 5 percent of the total population), but over the next 20 years that number will almost double. And the proportion of old old among that population -- the most infirm of our elderly -- will continue to grow. Nursing home care remains the single most reliable source of care for these dependent people, and billions of federal and state dollars (in addition to out-of-pocket expenditures) are spent with the expectation that quality nursing home care is being provided. Yet this is not necessarily the case, as the Committee's investigation should reveal today.

Mr. Chairman, I contend that even if less than one percent of the elderly population were institutionalized that quality care in these institutions should be among our nation's highest priorities. Our effectiveness as a nation should be measured by our ability to provide for those among us who are the most vulnerable, regardless of the size of that population. When I conducted my nursing home investigations back in the early 1970's, I found a deplorable situation in nursing homes. Since that time much has changed. Nursing home residents groups and concerned relatives groups have sprung up throughout the nation, national coalitions have become much more vocal about the needs of residents, and the Congress has worked (particularly over the last five years) tirelessly to prohibit the watering down of certification standards. Yet, for those facilities which are chronically out of compliance with federal regulations, conditions remain much like those that I saw years ago. This situation translates into untold human suffering, and the greatest tragedy of it all is that it should be avoidable.

Mr. Chairman, we all have a responsibility to ensure that adequate, quality care is given to nursing home residents. In coming months the Congress will be wrestling with issues related to the severe nursing home bed shortage, long term care insurance, expansion of incentives for facilities to participate in the Medicare program, hospital swing beds, national prospective rates for nursing home care, geriatric nursing home training, and others. Throughout our discussions we must do our best to ensure that quality care is provided at the most appropriate service level. We must also do our best to see that the problems associated with the Department of Health and Human Services new regulatory efforts are corrected. The Department is to be commended for redirecting survey and certification efforts toward the quality of care patients are actually receiving. However, the National Citizens Coalition for Nursing Home Reform and the Institute of Medicine study have confirmed the widespread concerns about:

-the implementation schedule;

-training guidelines and training follow-up;

-the provision for updates of surveyor guidelines;

-appropriate allocation of reimbursement resources; and

-the degree of public participatin in the survey process.

Mr. Chairman, these areas must be addressed adequately before we will be ready to move on to the other issues on the long term care agenda which I mentioned earlier. I want to thank you again for your timely scheduling of this hearing, and commend you for your efforts in this area. I look forward to today's testimony.

Chairman **Heinz**. Senator Chiles, former chairman of this committee, who I expect feels like he is having a second version of the same thing as well, a deja vu.

STATEMENT BY SENATOR LAWTON CHILES

Senator **Chiles**. Mr. Chairman, you are right, and I know the kind of concern that you have had and that all the members of the committee have had on this subject. I know what our colleague Senator Pryor is speaking about, because I know that as a Member of the House, he did an awful lot of work over there on nursing homes and trying to expose the problems that were there. And we thought that between the House and the Senate we had set some things in motion that would make this better.

I also know, Mr. Chairman, that over the last few years when we have tried to ask the administration, tried to talk about the fact that we saw that there were reduced numbers of inspections, also that there were reduced numbers of checks and certifications,[1] and we were told, "Not to worry. We have just changed our procedure. We are able to do this by a better method. We do not have to physically be there all the time. We have other monitoring processes that are doing this," and they assured us "everything is getting better." I have that same sort of feeling that everyone is expressing here. Finding, I guess, that those things which we feared the worst have actually come to pass and are actually out there. Finding that again we are talking about the people that cannot care for themselves, the ones that have no advocates and that cannot speak for themselves, and finding that these folks have not had the kind of care and attention that they deserve. It is a terrible indictment.

I think there is no more important subject that we could be dealing with. I am sorry that we are here dealing with this subject, but on the other hand, thank goodness we now have some information before us, maybe we can get about the task of trying to remedy the problems that are out there.

Chairman **Heinz**. Senator Chiles, thank you very much.

Senator Cohen was also very active in concerns involving aging as a Member of the House and has been one of the most active members of this committee, together with the Senator sitting to his right, Senator Chuck Grassley of Iowa.

Bill.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator **Cohen**. I have a very brief statement that I would like to submit for the record. I do not want to deprive our witness of his first opportunity to present some testimony before the committee.

I would like to offer a couple of comments. I heard some of our colleagues have made comments pointing the finger of blame at the Reagan administration. I would suggest that the problem goes back a lot further in time and indeed cannot be pointed to any one administration, Republican or Democrat. Both have been guilty, in my judgment, of a lack of either concern or initiative in this particular field.

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[1] See volume II, appendix 6, pp. 1, 67, 73, 87, 184, 283, 343-364, 372-378, 381, 383, 441, 467, and 481.

I also think that Congress, this panel even bears some measure of responsibility. On the one hand, we pass laws designed to create or deal with one set of problems only to create a different set of problems. For example, we were concerned about rising hospital costs, so we devised a new prospective payment scheme to try and rein-in the cost of hospital care for Medicare beneficiaries. So we passed this new legislation, and we indeed were successful in reining the hospital costs, only to create another set of problems by giving incentive to hospitals to shift the patients out and put them into nursing homes.

Of course, then the problem becomes one of a shortage of beds, giving the nursing homes undue leverage over who they are going to care for and how that care is going to be delivered.

There has also been another problem, and that is a lack of an effective enforcement mechanism for existing nursing home standards and regulations. We are either forced to shut down a nursing home that is in violation, thereby throwing the patients out into the street, or allowing the home to continue with the existing abuses. So we have not had very effective enforcement as well.

And, as noted before, Congress bears some measure of responsibility. Back in 1973, one of the first measures that Senator Heinz and I introduced in the House of Representatives was a nursing home patients' bill of rights. It did not go anywhere. It was introduced again in the 94th and the 95th Congresses and again in the Senate in 1979. Since that time, most of the provisions of that nursing home patients' bill of rights have been put into effect by way of regulation, but, as the staff study reveals, those regulations have not been very effectively enforced.

I recently reintroduced patients' rights legislation, the Long-Term Care Residents' Rights Act. Hopefully, we can enact this bill into law; but even so there is only one evil greater, it seems to me, than not having enough laws on the books: That is having laws on the books which go unenforced. This is the crux of the problem we are facing today. There are existing laws and regulations but they are not being effectively enforced. I am hopeful that through this hearing, Mr. Chairman, and your leadership, we will find a way to effectively enforce those laws.

Chairman HEINZ. Senator Cohen, thank you very much.

[The prepared statement of Senator Cohen follows:]

OPENING STATEMENT OF
SENATOR WILLIAM S. COHEN

before the

SPECIAL COMMITTEE ON AGING

MAY 21, 1986

MR. CHAIRMAN, I want to commend you for calling this hearing today to examine the issue of quality of care in nursing homes.

In the 1970s both Congress and the general public were shocked by studies revealing appallingly bad care in nursing homes in most parts of country. While it is generally agreed that conditions in nursing homes have improved since then, it is clear that there is much that can be done to ensure that all nursing home patients have access to quality care.

The results of the Aging Committee staff's investigation are re-enforced by the Institute of Medicine's long-awaited report on the quality of care in nursing homes released earlier this year. The Institute of Medicine's study concluded that, while the disturbing practices noted previously occur less frequently, serious problems of abuse and neglect continue to exist. The study found that in many government-certified nursing homes, "individuals who are admitted receive very inadequate -- sometimes shockingly deficient -- care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be subject to physical abuse."

The protection of "patients' rights" in long-term care facilities has long been one of my primary concerns. I first introduced legislation to guarantee the basic civil and human rights of nursing home patients in 1973, when I was a Member of the House of Representatives. I reintroduced similar legislation in the House in both the 94th and 95th Congresses, and again upon coming to the Senate in 1979. While many of the "rights" delineated in these early bills have been incorporated into the regulations governing long-term care facilities participating in medicare and medicaid, enforcement of these regulations has been woefully inadequate. Therefore, in February of this year I introduced the "Long-Term Care Residents' Rights Act," which would set in law a national standard of rights and basic guarantees to compassionate care for residents of nursing homes.

We are all appalled by reports of abuse and neglect of nursing home patients, and action must certainly be taken to ensure their health and safety. However, I believe that we should also be appalled by the accounts of patients being treated with disrespect -- of patients being viewed as incapable of making choices about things as simple as what to wear, when to wake up, and who to see. Far too often these decisions are made for the convenience of the facility, not for the comfort of the patients. While problems related to "patients' rights" in nursing homes may, at first glance, seem less urgent than outright abuse or neglect, I believe that they are intrinsically related to the quality of care issue in that they are essential to quality of life. Quality health care encompasses not simply medical treatment, but also a basic understanding and respect for the patient as an individual and a human being. This is particularly important given the fact that for many long-term care patients, the nursing home is both a permanent and final residence.

Chairman HEINZ. Senator Chuck Grassley.

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Yes; I think—taking off from where Senator Cohen just finished—I think it is clear that we do need an improvement in performance standards, in inspections and in enforcement. And of course, we need this at a time that as the graying of America continues, there is little doubt that the long-term-care component of our health care system is going to become an increasingly important one to increasing numbers of Americans falling in that category.

Now, despite progress toward this goal, there are still problems in the deliverance of long-term-care. In many States, there is a shortage of nursing beds. The incentives in Medicare's prospective payment system have increased the pressure on the availability of beds, people being put out of hospitals quicker and consequently, sicker.

Studies have also shown that Medicaid-eligible elderly are suffering disproportionately from the lack of access to nursing home beds when private pay and patients with lower needs are accepted in lieu of needy Medicare elderly.

Another concern that I have, Mr. Chairman, is the number of nursing homes that are chronically found out of compliance with the minimum quality standards, and yet they continue to operate; and of course, certainly, the influx of heavier care patients and limited Medicare reimbursement have made the provision of care more difficult for the nursing homes.

However, we need to examine the performance of the Health Care Financing Administration, and this hearing is doing that, in regard to how effectively they are monitoring compliance with health and safety standards. And of course, we all recognize that HCFA has taken steps to improve its database to deal with the repeat offenders in the long-term care system and to reform its survey process. Yet it appears that HCFA needs to more clearly provide guidance and assistance to States—and particularly I feel this way about my State of Iowa—in interpreting its quality regulations.

Congress, of course, as Senator Cohen said, can help by putting some teeth into the enforcement mechanism by providing authority for HCFA to employ intermediate sanctions or penalties short of cutting off all Federal funds.

So there are many different aspects of this, and I am sure this oversight hearing and the work of this committee will bring it out so that we can have a more clear direction.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. Chairman, I appreciate the opportunity to participate in this hearing this morning. I would first like to take just a moment to welcome our first witness, the new Administrator of the Health Care Financing Administration, Dr. William Roper. Congratulations, Dr. Roper, on your recent Senate confirmation and I look forward to working with you through my committee memberships on this committee, the Finance Committee and Labor and Human Resources Committee.

Mr. Chairman, as the "graying" of America continues, there is little doubt that the long-term care component of our health care system will become an increasingly important one. Now during the last 15 years, we have experienced an improvement in nursing home care and regulation. I think it is clear, however, that improvement is needed in the areas of performance standards, inspection, and enforcement. Congress needs to continue to work toward assurance that the 1.5 million residents in our Nation's 15,000 nursing homes are receiving high quality care.

Despite progress toward this goal, there are still problems in the deliverance of long-term care. In many States, a shortage of nursing beds exist and finding a nursing home bed that offers quality care is difficult. The incentives in Medicare's perspective payment system have increased the pressure on availability of beds, as patients are being released from our hospitals quicker and sicker. Studies have also shown that Medicaid-eligible elderly are suffering disproportionately from lack of access to nursing home beds, when private pay and patients with lower needs are accepted in lieu of needy Medicare elderly.

Another concern is the number of nursing homes that are chronically found out of compliance with minimum quality standards, yet continue to operate. Certainly, the influx of heavier care patients and limited Medicare reimbursement have made the provision of care more difficult for nursing homes. However, we need to examine the performance of the Health Care Financing Administration in effectively monitoring compliance with health and safety standards. I recognize that HCFA has taken steps to improve its data base to deal with repeat offenders in the long-term care system and to reform its survey process. Yet it appears that HCFA needs to more clearly provide guidance and assistance to States in interpreting its quality regulations. Congress, as well, can help put teeth into enforcement mechanisms by providing authority for HCFA to employ intermediate sanctions or penalties, short of cutting off all Federal funds.

Mr. Chairman, we recognize that the population in our nursing homes is a vulnerable one. I am hopeful that our hearing this morning can provide us direction to better ensure that our nursing home residents receive appropriate care, are treated with dignity and continue to enjoy their legal and civil rights.

Chairman HEINZ. Senator Grassley, thank you very much.

Senator Pressler.

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Well, I thank you very much, and I shall submit an opening statement for the record. I just want to say that it is my feeling that in my home State of South Dakota, we do not have so much of a problem in that we have very dedicated employees in nursing homes. However, maybe we have more of a problem than I think. So I think it is very appropriate for us to be looking into this subject. I will submit a written statement for an opening statement.

Chairman HEINZ. Very well. Thank you very much, Senator Pressler. Without objection, so ordered.

[The prepared statement of Senator Pressler follows:]

STATEMENT OF SENATOR LARRY PRESSLER

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

NURSING HOME CARE: UNFINISHED AGENDA

WEDNESDAY, MAY 21, 1986

LET ME BEGIN BY THANKING THE CHAIRMAN FOR HOLDING THIS HEARING ON NURSING HOME CARE. I HAVE BEEN ACTIVELY INVOLVED IN SENIOR CITIZENS' ISSUES SINCE FIRST COMING TO CONGRESS, AND THE QUALITY OF CARE IN OUR NURSING HOMES CONSISTENTLY TOPS THE LISTS OF PRIORITIES FOR THOSE INVOLVED IN AGING CONCERNS. I HOPE THE TESTIMONY SHARED HERE TODAY WILL SHED NEW LIGHT ON THE PROBLEM OF SUBSTANDARD CARE, AND LEAD TO REFORMS IN THIS AREA.

THE CARE OUR NATION'S ELDERLY RECEIVE IN NURSING HOMES, THE SUBJECT OF TODAY'S HEARING, AND IS POSSIBLY ONE OF THE MOST IMPORTANT SUBJECTS THAT WILL BE EXAMINED BY THIS COMMITTEE. THE ELDERLY POPULATION IS GROWING EVERY YEAR IN THE UNITED STATES DUE TO ADVANCES IN MEDICAL TECHNOLOGY. PEOPLE ARE LIVING LONGER AND THE NEED FOR NURSING HOMES IS INCREASING. THIS NEED, HOWEVER, MUST BE MET IN THE MOST CONSCIENTIOUS MANNER. THE ELDERLY IN THESE NURSING HOMES ARE NOT JUST A CATEGORIZED SECTOR OF OUR SOCIETY, BUT OUR GRANDPARENTS, PARENTS, AUNTS, UNCLES, AND OTHER RELATIVES. THEY ARE OUR LOVED ONES WHO DESERVE THE BEST POSSIBLE CARE AVAILABLE.

THE SENATE COMMITTEE ON AGING STAFF REPORT HAS PRODUCED SOME VERY EYE-OPENING STATISTICS REGARDING THE NUMBER OF SUBSTANDARD SKILLED NURSING FACILITIES IN OUR COUNTRY. AS WE HEAR TESTIMONY

FROM THE TWO DISTINGUISHED PANELS OF WITNESSES, I HOPE WE CAN ALL GAIN A BETTER PERSPECTIVE ON THE PROBLEM OF NURSING HOMES WHICH ARE NOT MEETING CRITICAL HEALTH AND QUALITY OF CARE STANDARDS. THE ENFORCEMENT OF FEDERAL STANDARDS MUST BE GIVEN PRIORITY BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE FASTEST GROWING SECTOR OF THE POPULATION IS THAT OF PEOPLE BETWEEN THE AGES OF 60 AND 80 YEARS. THIS TREND WILL FURTHER INCREASE THE NEED FOR NURSING HOMES IN TODAY'S SOCIETY AND MAGNIFY STATE AND FEDERAL GOVERNMENT'S RESPONSIBILITY IN REGULATING THESE FACILITIES AND IN ENFORCING THOSE REGULATIONS.

IN ADDITION, WE MUST FOCUS UPON THE REASONS NURSING HOMES ARE DEFICIENT IN MEETING CRITICAL CARE STANDARDS. THE IMPACT OF THE IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM HAS LARGELY CONTRIBUTED TO THE GREATER DEMAND FOR COMPLEX CARE, AND A GREATER NEED FOR NURSING HOMES TO PROVIDE THIS CARE. SHORTER HOSPITAL STAYS HAVE RESULTED IN CROWDED NURSING HOMES FOR RECUPERATION AND PROFESSIONAL CARE. CONGRESS, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE HEALTH CARE FINANCING ADMINISTRATION, AND STATE OFFICIALS MUST WORK TOGETHER TO PROVIDE THE BEST CARE POSSIBLE FOR THOSE ELDERLY CITIZENS IN NURSING HOMES.

AGAIN, I WOULD LIKE TO THANK THE CHAIRMAN FOR HOLDING A HEARING ON THE VITAL ISSUE OF NURSING HOME CARE, AND I LOOK FORWARD TO HEARING THE TESTIMONY OF THE KNOWLEDGEABLE WITNESSES ASSEMBLED HERE TODAY.

Chairman HEINZ. Well, Dr. Roper, you are the new, brand new, squeaky-clean new, Administrator of the Health Care Financing Administration. Of all the people in this half-circle up here, you are one person who cannot yet be part of the problem. [Laughter.]

And I do think I speak for the entire committee that we have great expectations, Dr. Roper, as you take hold of the reins of the agency most responsible for the health care of older Americans. I think we all know, too, that running an agency with so many programs, and they are so critical to the well-being of the elderly and the poor of this Nation, that is going to be no easy task.

So we welcome you here today, and this committee does indeed look forward to working with you in your new capacity. When you were confirmed by the Finance Committee a few weeks ago and you and I visited, little did you or I know that your first official visitation to the Hill would be in this capacity.

So we very much appreciate your being here, and we look forward to hearing your views.

If you do summarize your statement, let me assure you your full statement will be made a part of the record.

Please proceed.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. ROPER. Thank you, sir.

Mr. Chairman, members of the committee, I am Bill Roper, Administrator of the Health Care Financing Administration. I am pleased to have the opportunity to meet with you today and to discuss our contributions to the overall agenda to assure the health, safety, and rights of Medicare and Medicaid beneficiaries in nursing home facilities.

As Senator Heinz has just said, I am personally interested in this subject. He and I talked about my commitment as a physician to quality of care, and Secretary Bowen has done the same. I am glad to be here today.

I have gained a great deal of experience with nursing homes with issues concerning quality of care, and with cooperation between States and the Federal Government during my years as a local and State health official in Alabama. I believe that experience will serve me well in my tenure as Administrator of HCFA when dealing with the issue of nursing home regulation.

The quality of care in nursing homes in America has improved significantly since the original survey and certification monitoring system was first implemented for Medicare and Medicaid in 1974. Today, with the help and cooperation of the States, we are able to use a number of tools to monitor skilled nursing facilities providing care to both Medicare and Medicaid beneficiaries and intermediate care facilities for Medicaid recipients, and to correct problems which directly affect the well-being of those elderly and disabled recipients.

The President, Secretary Bowen and I are fundamentally committed to ensuring quality of care in Medicare and Medicaid. Beneficiaries of these programs and their families rightfully expect that of us.

We think we have a sound and effective program, but we realize that in any program there are always additional improvements that can be made.

I want to share with you today our current monitoring efforts and our planned future activities to strive for the best care in nursing homes for all Medicare and Medicaid beneficiaries.

Before I get into that, I just want to say I am glad that this is my first hearing, Senator Heinz. And if I can share with you a personal note, about a year ago, my mother died after a 10-year illness with Alzheimer disease. The last year of her life she spent in a nursing home. So I bring to this issue not only professional concern, but personal as well.

HCFA contracts with States to inspect or survey to determine if a nursing home facility meets the Federal conditions of participation and standards. This is referred to as the survey and certification process.

State agency personnel perform initial surveys and periodic resurveys of nursing homes at least annually. Surveyors make additional unannounced visits between regular visits to determine the status of a previously identified problem or to investigate complaints.

Identified problems result either in the facility submitting a written plan of correction or, if there are more serious problems, our terminating it from the Medicare and/or Medicaid Programs.

Termination is the last resort, but we will not hesitate to exercise that authority to terminate facilities. In fact, last year 130 skilled nursing facilities and 108 intermediate care facilities were terminated from participation under the Medicare and Medicaid Programs.[2]

We are working aggressively to improve this process further. We implemented revised termination procedures[3] last December with the States to expedite the termination of substandard nursing homes.

These new procedures accelerate the process for terminating facilities with intermediate and serious threat situations. We are beginning to see the effects of these termination procedures already on all segments of the nursing home systems. Beneficiaries have added assurance that they will get quality care in that facility, or they will be relocated to another facility.

I was in touch yesterday with my colleagues in the Alabama Department of Public Health and talked with them about their enforcement of these new termination instructions, and they say this has made a real step forward in the process.

HCFA conducts Federal onsite surveys through our regional offices of a sample of all types of facilities to determine the extent that State survey agencies accurately identify facility deficiencies. It is referred to as look behind.

During fiscal year 1985, we performed 464 of these look behind surveys, and this year, we plan to complete 800 of them. Next year the budget calls for continued aggressive use of the authority, with resurveys heavily targeted at facilities that have a pattern of noncompliance.[4]

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[2] Staff note: decertified facilities were counted twice if they were certified as ICF and as SNF.

[3] See, volume II, appendix 6, p. 630.

I assure you that our record in this area of look behind resurveys has made our commitment to enforcement quite clear to those who might think otherwise.

But the current survey process focuses on physical plant and written policies to determine quality of care in nursing homes. Beginning in 1982, the Department began developing a modified survey process that would focus on the actual care given, rather than on process requirements. The result of this new work is a survey tool, a new tool, which is commonly referred to as the patient care and services or PACS tool. The final regulation implementing PACS should be published in the very near future.[5]

PACS has two key features. First, it is a resident-centered approach which provides a more valid estimate of the quality of care furnished by the facilities. It brings the surveyors face to face with the residents of nursing homes. It is not simply a paper audit.

And, second, PACS requires surveyors to follow specific procedures and to review according to a specified checklist, thereby achieving greater consistency in survey methods and findings. It focuses especially on the care that is given, on the nutrition and on the meals that patients receive, and on the drugs that are administered and how they are administered in nursing homes.

Much of the PACS effort has been made possible by the full cooperation of consumer advocates, the nursing home industry, and representatives of State governments. That gives us confidence that we have indeed taken a major step toward improving our assessment of nursing home care.

If a State survey agency determines that a SNF or ICF providing care to Medicaid and Medicare beneficiaries did not comply with one or more of the conditions of participation or standards, the only sanction available to HCFA or the State Medicaid agency is to terminate the facility's provider agreement. Under final regulations, which should be issued in the very near future, HCFA and the States will have an alternative to terminating Medicare and Medicaid provider agreements with facilities found to be out of compliance.[6]

In facilities that have deficiencies which do not pose immediate jeopardy to the health and safety of patients, HCFA and State Medicaid agencies will have the option of either terminating the facility's provider agreement or exercising an intermediate sanction. This intermediate sanction would deny payment for new admissions for a period of up to 11 months while the deficiencies are being corrected.

If a nursing home which has been levied this intermediate sanction remains out of compliance at the end of the period, the Secretary will begin termination procedures immediately.

Even though we feel we do a good job in addressing problems and complaints about nursing home care as they are identified, we know the system is not perfect. Both monitoring of nursing homes and coverage of such care for Medicare and Medicaid recipients need continuing examination and improvement.

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[4] "Please see appendix 1, testimony of the General Accounting Office."

[5] "Please see Federal Register, June 13, 1986, page 21550."

[6] "Please see Federal Register, July 3, 1986, page 24484."

Beginning in 1983, we funded a study conducted by the Institute of Medicine to look at the full range of nursing home regulatory and enforcement issues and to provide recommendations for changes in the system. This study, which cost $1.6 million, was completed in March, and HCFA has begun a careful review of the study's comments and recommendations.[7] We feel that a report with such scope and complexity deserves an equally thorough review by the Department before responding to the study's recommendations.

I assure you that the Secretary and I will fully examine these issues and make decisions in the best interests of those we serve.

Finally, Mr. Chairman, we are fully committed to protecting our elderly and sick who reside in nursing homes. I think this commitment is clearly evidenced by the work we have already done, but more importantly by the fact that we are continuing to seek improvements in both our requirements and in our enforcement systems.

Let me again mention that I look forward to working with you individually and with the committee and with the Congress in general to further improve these programs. This is an important time in the evolution of care for the residents in nursing homes. I have indicated our commitment to resolving problems, and we will strive to assure that nothing less than quality care is provided to all those residents.

I would be pleased to answer your questions.

Chairman HEINZ. Dr. Roper, thank you very much.

[The prepared statement of Dr. Roper follows:]

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[7] "Please see volume II, appendix 6, HCFA memorandum dated 9/5/86; see also related memorandum from the Administration on Aging, dated 7/10/86."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

MAY 21, 1986

Mr. Chairman and members of the Committee, I am William L. Roper, Administrator of the Health Care Financing Administration. I would like to thank you for this opportunity to discuss our contributions to the agenda to assure the health, safety, and rights of Medicare and Medicaid beneficiaries in nursing home facilities. The individuals in nursing homes generally suffer from any of a number of physical, functional, and mental disabilities; they most assuredly deserve the full protection of the Federal government.

The quality of care provided in nursing homes has improved over the past decade since the original survey and monitoring system was first implemented for Medicare and Medicaid. The current survey system, which has been in effect since 1974, was implemented to address the many shortcomings in nursing home care that became evident in the late 1960s and early 1970s. Today, with the help and cooperation of the States, we are able to use a number of tools to monitor skilled nursing facilities (SNFs) providing care to both Medicare and Medicaid beneficiaries and intermediate care facilities (ICFs) for Medicaid recipients, and to correct problems which directly affect the well-being of those elderly and disabled residents.

We feel that the current system for assuring quality care in nursing homes has been successful in ensuring appropriate care in a safe environment. Although we have had a high degree

OF SUCCESS, I WOULD BE THE FIRST TO ADMIT THAT WE ARE NOT PERFECT. HCFA IS RESPONSIBLE FOR CARE IN ALMOST 50,000 HEALTH CARE FACILITIES IN THE UNITED STATES, OF WHICH ABOUT 20,000 ARE NURSING HOMES PROVIDING CARE TO MORE THAN 1.75 MILLION MEDICARE AND MEDICAID RECIPIENTS. WITH SO MANY FACILITIES PROVIDING CARE TO SO MANY PERSONS, IT IS INEVITABLE THAT ISOLATED INCIDENCES OF SUBSTANDARD CARE WILL OCCUR. OF COURSE, WHEN WE LEARN OF THESE CASES WE REACT IMMEDIATELY AND WILL NEVER BE SATISFIED UNTIL THERE ARE NO SUCH INSTANCES.

WE THINK WE HAVE A SOUND AND EFFECTIVE PROGRAM, BUT WE REALIZE THAT IN ANY PROGRAM THERE ARE ALWAYS ADDITIONAL IMPROVEMENTS THAT CAN BE MADE. I WOULD LIKE TO SHARE WITH YOU TODAY OUR CURRENT MONITORING EFFORTS AND FUTURE ACTIVITY TO STRIVE FOR THE BEST CARE IN NURSING HOMES FOR ALL MEDICARE AND MEDICAID BENEFICIARIES.

CURRENT ACTIVITIES

STATE AND FEDERAL SURVEYS

TO ASSURE THAT HIGH QUALITY CARE IS AFFORDED MEDICARE AND MEDICAID BENEFICIARIES, WE WORK WITH THE STATES TO ENFORCE FEDERAL CONDITIONS OF PARTICIPATION (FOR SNFS) AND STANDARDS (FOR ICFS). HCFA CONTRACTS WITH STATES TO INSPECT, OR SURVEY, TO DETERMINE IF A NURSING HOME FACILITY MEETS THE FEDERAL CONDITIONS OF PARTICIPATION AND STANDARDS.

THE PROCESS FOLLOWED BY STATE SURVEY AGENCIES IS REFERRED TO AS THE "SURVEY AND CERTIFICATION PROCESS." THIS PROCESS IS ESTABLISHED BY LAW, IMPLEMENTED AND ENFORCED BY REGULATIONS, AND INTERPRETED IN PROCEDURAL REQUIREMENTS THAT MUST BE FOLLOWED BY THE STATE AND FEDERAL AGENCIES INVOLVED IN THE SURVEY AND CERTIFICATION PROCESS.

STATE AGENCY PERSONNEL PERFORM INITIAL SURVEYS AND PERIODIC RESURVEYS OF NURSING HOMES AT LEAST ANNUALLY. THESE SURVEYS:

- ASSESS THE EXTENT AND DEGREE TO WHICH EACH FACILITY IS IN COMPLIANCE WITH THE REGULATORY REQUIREMENTS; AND
- OBTAIN AN OVERALL EVALUATION OF A FACILITY'S PERFORMANCE AND EFFECTIVENESS IN RENDERING APPROPRIATE AND SAFE PATIENT CARE.

SURVEYORS MAY MAKE ADDITIONAL UNANNOUNCED VISITS BETWEEN REGULAR VISITS TO DETERMINE THE STATUS OF A PREVIOUSLY IDENTIFIED PROBLEM OR TO INVESTIGATE COMPLAINTS. IDENTIFIED PROBLEMS CAN RESULT IN A STATEMENT OF DEFICIENCIES FOR WHICH THE FACILITY MUST SUBMIT A WRITTEN PLAN OF CORRECTION. THIS INFORMATION IS THE BASIS FOR CONDUCTING FOLLOW-UP OR MONITORING ACTIVITIES TO ASCERTAIN PROGRESS AND ASSIST THE FACILITY IN CARRYING OUT ITS CARE REQUIREMENTS. IF THE FACILITY HAS MORE SERIOUS COMPLIANCE PROBLEMS, IT IS TERMINATED FROM THE MEDICARE AND/OR MEDICAID PROGRAM.

WHILE TERMINATION IS THE LAST RESORT, WE WILL NOT HESITATE TO EXERCISE OUR AUTHORITY AND TERMINATE FACILITIES. DURING FISCAL YEAR 1985, 130 SNFS AND 108 ICFS WERE TERMINATED FROM PARTICIPATION UNDER THE MEDICARE AND MEDICAID PROGRAMS.

NEW TERMINATION INSTRUCTIONS

IN ORDER TO EXPEDITE THE TERMINATION OF SUBSTANDARD NURSING HOMES, WE IMPLEMENTED REVISED TERMINATION PROCEDURES IN DECEMBER 1985. THE NEW PROCEDURES WILL:

- o ACCELERATE THE PROCESS FOR TERMINATING FACILITIES WITH IMMEDIATE AND LIFE-THREATENING SITUATIONS;
- o SET PROCESSING TIME LIMITS FOR ALL STEPS IN THE TERMINATION PROCESS;
- o CLARIFY PROCEDURES AND PROGRAM REQUIREMENTS; AND
- o MONITOR CAREFULLY ADHERENCE TO PROCEDURES FOR TERMINATION.

WE SHOULD BEGIN TO SEE THE EFFECTS OF THESE NEW TERMINATION PROCEDURES ON ALL SEGMENTS OF THE NURSING HOME SYSTEM. BENEFICIARIES WILL BE EVEN FURTHER ASSURED THAT CARE AND SERVICES OF HIGH QUALITY WILL BE FURNISHED BY FACILITIES AND THAT, IF NECESSARY, THEY WILL BE RELOCATED TO NURSING HOMES THAT FURNISH THE REQUIRED LEVEL AND QUALITY OF CARE. PROVIDERS WILL BE GIVEN A CLEAR STATEMENT OF PROGRAM REQUIREMENTS AND WILL HAVE INCREASED INCENTIVES TO IMMEDIATELY CORRECT DEFICIENCIES. STATES AND REGIONAL OFFICES WILL BE REWARDED WITH UNIFORM

PROGRAM REQUIREMENTS AND WILL HAVE THEIR ROLES AND FUNCTIONS CLARIFIED IN THE ENFORCEMENT PROCESS.

FEDERAL MONITORING

AS PART OF ITS ROLE IN OVERSEEING THE OPERATION OF THE SURVEY PROCESS, HCFA CONDUCTS FEDERAL ONSITE SURVEYS THROUGH OUR REGIONAL OFFICES OF A SAMPLE OF ALL TYPES OF FACILITIES TO DETERMINE THE EXTENT THAT STATE SURVEY AGENCIES ACCURATELY IDENTIFY FACILITY DEFICIENCIES. WHEN HCFA REVIEWS CERTIFICATION OF FACILITIES THAT PARTICIPATE ONLY IN MEDICAID, IT IS REFERRED TO AS "LOOK BEHIND," I.E., A LOOK BEHIND OF THE STATE DECISION TO CERTIFY. THIS IS SPECIAL AUTHORITY CONGRESS GAVE THE SECRETARY TO MAKE INDEPENDENT DETERMINATIONS OF FACILITIES COMPLIANCE WITH FEDERAL REQUIREMENTS

IN FISCAL YEAR 1985, WE BEGAN INITIATIVES TO INCREASE OUR USE OF THE LOOK BEHIND AUTHORITY. BECAUSE OF THE PARTICULAR VULNERABILITY OF THE RESIDENTS AND IDENTIFIED PROBLEMS, HIGHEST PRIORITY WAS ACCORDED PUBLIC ICFS FOR THE MENTALLY RETARDED.

DURING THAT YEAR WE PERFORMED 464 LOOK BEHIND SURVEYS AND IN FISCAL YEAR 1986, WE PLAN TO COMPLETE 800 RESURVEYS. OUR FISCAL YEAR 1987 BUDGET CALLS FOR CONTINUED, AGGRESSIVE USE OF THE AUTHORITY WITH RESURVEYS HEAVILY TARGETED AT FACILITIES THAT HAVE A PATTERN OF NONCOMPLIANCE WITH CARE REQUIREMENTS.

I ASSURE YOU THAT OUR RECORD IN THIS AREA HAS MADE OUR COMMITMENT TO ENFORCEMENT QUITE CLEAR TO THOSE WHO MIGHT THINK OTHERWISE.

PATIENT CARE AND SERVICES (PACS) TOOL

THE CURRENT SURVEY PROCESS FOCUSES ON PHYSICAL PLANT AND WRITTEN POLICIES ON THE ASSUMPTION THAT IF CERTAIN STRUCTURES ARE SAFE, QUALIFIED STAFF ARE PROPERLY DEPLOYED, AND APPROPRIATE PROCESSES ARE IN PLACE, GOOD CARE WILL BE ATTAINED. HOWEVER, IT HAS BECOME EVIDENT TO EVERYONE CONCERNED ABOUT NURSING HOME CARE THAT IT IS IMPORTANT TO EMPHASIZE OUTCOMES THROUGH THE SURVEY PROCESS.

BEGINNING IN 1978, THE DEPARTMENT APPROVED A NUMBER OF DEMONSTRATIONS AND EXPERIMENTS WITH THE OBJECTIVE TO DEVELOP A MODIFIED SURVEY PROCESS THAT WOULD IMPROVE SURVEY AND CERTIFICATION FOCUSING ON ACTUAL CARE DELIVERED RATHER THAN PROCESS REQUIREMENTS.

IN 1982, HCFA BEGAN TO DEVISE A NEW SURVEY TOOL, BASED ON THE RESULTS OF THOSE EXPERIMENTS, WHICH IS COMMONLY REFERRED TO AS THE PATIENT CARE AND SERVICES (PACS) TOOL. WE PUBLISHED A NOTICE OF PROPOSED RULEMAKING IN THE FEDERAL REGISTER ON THE PACS SURVEY TOOL ON OCTOBER 31, 1985, AND THE FINAL RULE SHOULD BE PUBLISHED AND IMPLEMENTED IN THE NEAR FUTURE.

PACS HAS TWO KEY FEATURES:

- O FIRST, IT IS A RESIDENT-CENTERED APPROACH. IT PROVIDES A MORE VALID ESTIMATE OF THE QUALITY OF CARE FURNISHED BY THE FACILITY. BY BRINGING SURVEYORS FACE-TO-FACE WITH A REPRESENTATIVE SAMPLE OF PATIENTS OR RESIDENTS, IT ENABLES SURVEYORS TO MORE ACCURATELY IDENTIFY THEIR NEEDS AND PROBLEMS, AND, SUBSEQUENTLY, TO DETERMINE HOW WELL CARE IS PROVIDED TO MEET THESE NEEDS.
- O SECOND, BY REQUIRING SURVEYORS TO FOLLOW SPECIFIC PROCEDURES AND TO REVIEW ACCORDING TO A SPECIFIED CHECKLIST, IT ACHIEVES GREATER CONSISTENCY IN SURVEY METHODS AND FINDINGS.

ALTHOUGH IT STILL ENSURES COMPLIANCE WITH ALL FEDERAL REQUIREMENTS, THE MOST INNOVATIVE PACS COMPONENTS ARE THE THREE ACTIVITIES THAT FOCUS ON A SAMPLE OF THE PATIENTS OR RESIDENTS:

- O INDEPTH REVIEW OF FURNISHED CARE THROUGH OBSERVATION, INTERVIEW AND RECORD REVIEW;
- O EVALUATION OF MEALS, DINING AND EATING ASSISTANCE; AND
- O EVALUATION OF DRUG ADMINISTRATION.

AS A RESULT OF THESE REVIEWS OF PATIENTS AND STAFF, A SURVEYOR CAN IDENTIFY PATTERNS AND AREAS WHERE THE FACILITY APPEARS TO HAVE PROBLEMS IN ADDRESSING AND PROVIDING CARE. THE SURVEYOR CAN THEN DETERMINE, BASED ON THE NATURE AND NUMBER OF THESE FINDINGS, WHETHER DEFICIENCIES EXIST AND DISCUSS THEM WITH FACILITY STAFF.

A GREAT DEAL OF THE PACS EFFORT HAS BEEN MADE POSSIBLE BY THE FULL COOPERATION OF CONSUMER ADVOCATES, THE NURSING HOME INDUSTRY, AND REPRESENTATIVES OF STATE GOVERNMENTS. IN FACT, THE CONTINUING SUPPORT OF ALL THESE GROUPS AND THEIR ENDORSEMENT OF OUR ACTIONS HAS GIVEN US CONFIDENCE THAT WE HAVE INDEED TAKEN A MAJOR STEP TOWARD IMPROVING OUR ASSESSMENT OF CARE RENDERED IN NURSING HOMES.

INTERMEDIATE SANCTIONS

AS I DESCRIBED EARLIER, IF A STATE SURVEY AGENCY DETERMINES THAT A SNF OR ICF PROVIDING CARE TO MEDICARE AND MEDICAID BENEFICIARIES DID NOT COMPLY WITH ONE OR MORE OF THE CONDITIONS OF PARTICIPATION OR STANDARDS, THE ONLY SANCTION AVAILABLE TO HCFA OR THE MEDICAID AGENCY IS TO TERMINATE THE FACILITY'S PROVIDER AGREEMENT. WHILE WE HAVE RECENTLY IMPLEMENTED THE NEW TERMINATION PROCEDURES, TERMINATION OF A FACILITY IS SOMETIMES NEITHER FEASIBLE NOR DESIRABLE.

UNDER FINAL REGULATIONS WHICH SHOULD BE ISSUED IN THE NEAR FUTURE, HCFA AND STATES WILL HAVE AN ALTERNATIVE TO TERMINATING MEDICARE AND MEDICAID PROVIDER AGREEMENTS WITH FACILITIES THAT ARE FOUND TO BE OUT OF COMPLIANCE. IN FACILITIES WITH DEFICIENCIES THAT DO NOT POSE IMMEDIATE JEOPARDY TO THE HEALTH AND SAFETY OF PATIENTS, HCFA AND STATE MEDICAID AGENCIES WILL HAVE THE OPTION OF EITHER TERMINATING THE AGREEMENT OR DENYING

PAYMENT FOR NEW ADMISSIONS FOR A PERIOD OF UP TO 11 MONTHS WHILE DEFICIENCIES ARE CORRECTED. IF A HOME WHICH HAS BEEN LEVIED THE INTERMEDIATE SANCTION REMAINS OUT OF COMPLIANCE AT THE END OF THIS PERIOD, THE SECRETARY IS TO BEGIN TERMINATION PROCEDURES IMMEDIATELY.

THIS NEW ENFORCEMENT TOOL IS INTENDED TO ENSURE THE UNINTERRUPTED STAY OF A NURSING HOME'S PATIENTS WHILE PROTECTING THEM FROM POTENTIALLY HARMFUL EFFECTS ARISING FROM PROLONGED EXPOSURE TO SUBSTANDARD CONDITIONS. WHERE APPROPRIATE, WE INTEND TO UTILIZE THIS AUTHORITY AGGRESSIVELY AGAINST FACILITIES PROVIDING LESS THAN ADEQUATE LEVELS OF CARE.

FUTURE ACTIVITY

AS I NOTED, EVEN THOUGH WE FEEL THAT WE DO A GOOD JOB IN ADDRESSING PROBLEMS AND COMPLAINTS ABOUT NURSING HOME CARE AS THEY ARE IDENTIFIED, WE KNOW THAT THE SYSTEM IS NOT PERFECT. BOTH MONITORING OF NURSING HOMES AND COVERAGE OF SUCH CARE FOR MEDICARE AND MEDICAID RECIPIENTS NEED CONTINUING EXAMINATION AND IMPROVEMENT. I WOULD LIKE TO BRIEFLY DESCRIBE FOR YOU OUR REVIEW OF A RECENTLY RELEASED STUDY BY THE INSTITUTE OF MEDICINE.

THE NURSING HOME REGULATORY AND ENFORCEMENT REQUIREMENTS HAVE IN THE PAST BEEN THE SUBJECT OF MUCH REVIEW AND PROPOSED REVISION.

UNFORTUNATELY, THESE ARE CONTROVERSIAL AREAS WHERE KNOWLEDGEABLE PEOPLE WITH STRONG OPINIONS AS WELL AS GOOD INTENTIONS SOMETIMES DISAGREE. TO HELP DEAL WITH THESE ISSUES IN AN OBJECTIVE MANNER, IN OCTOBER 1983 WE FUNDED THE INSTITUTE OF MEDICINE (IOM) OF THE NATIONAL ACADEMY OF SCIENCES TO STUDY THE FULL RANGE OF NURSING HOME REGULATORY AND ENFORCEMENT ISSUES AND TO PROVIDE RECOMMENDATIONS FOR CHANGES TO THE SYSTEM.

THE $1.6 MILLION STUDY WAS COMPLETED WITH THE ISSUANCE OF THE IOM'S REPORT IN MARCH OF THIS YEAR. HCFA HAS BEGUN A CAREFUL REVIEW OF THE IOM'S COMMENTS AND RECOMMENDATIONS TO DETERMINE WHAT IMPROVEMENTS CAN BE MADE TO THE CURRENT LONG-TERM CARE SYSTEM. HOWEVER, WE FEEL THAT A REPORT WITH SUCH SCOPE AND COMPLEXITY DESERVES AN EQUALLY THOROUGH AND EXHAUSTIVE REVIEW BY THE DEPARTMENT PRIOR TO RESPONDING TO THE STUDY'S RECOMMENDATIONS. I ASSURE YOU THAT BOTH THE SECRETARY AND I WILL FULLY EXAMINE THESE ISSUES AND MAKE DECISIONS IN THE BEST INTERESTS OF THOSE WE SERVE.

SUMMARY

MR. CHAIRMAN, WE ARE FULLY COMMITTED TO PROTECTING OUR ELDERLY AND SICK WHO RESIDE IN NURSING HOMES. I THINK THIS COMMITMENT IS CLEARLY EVIDENCED BY THE WORK WE HAVE DONE TO DATE, BUT, MORE IMPORTANTLY, BY THE FACT THAT WE ARE CONTINUING TO SEEK

IMPROVEMENTS IN BOTH OUR REQUIREMENTS AND ENFORCEMENT SYSTEMS. WE ARE ABOUT TO IMPLEMENT THE PATIENT-ORIENTED PACS SURVEY TOOL WHICH WILL IMPROVE OUR ASSESSMENT OF CARE RENDERED IN NURSING HOMES. WE HAVE INAUGURATED NEW TERMINATION PROCEDURES TO SWIFTLY DEAL WITH NURSING HOMES WHICH FAIL TO CORRECT SUBSTANDAR DEFICIENCIES IN AN EXPEDITIOUS MANNER. THE INTERMEDIATE SANCTIONS REGULATIONS WILL BE IMPLEMENTED SOON AND WILL BE ANOTHER WEAPON IN OUR ARSENAL TO COMBAT SUBSTANDARD CARE. TO CONSIDER FUTURE OPTIONS IN MONITORING ACTIVITIES, WE ARE REVIEWING THE IOM STUDY.

THIS IS AN EXCITING TIME IN THE EVOLUTION OF CARE FOR RESIDENTS IN NURSING HOMES. WE HAVE INDICATED OUR COMMITMENT TO RESOLVING PROBLEMS AND WE WILL STRIVE TO ASSURE THAT NOTHING LESS THAN HIGH QUALITY CARE IS PROVIDED TO ALL THOSE RESIDENTS.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS THE COMMITTEE MAY HAVE.

Let us assume that you do need some time to study your study, and integrate it with what you want to do. How long will it take you to decide whether or not to make changes?

Dr. ROPER. Senator, we want to do it very quickly. The PACS recommendation, is not a perfect answer to the problem of assuring quality, but everybody who has taken a look at it thinks it is better than what we have got right now. And while we are waiting on the perfect, we do not want to hold off implementing the good, and so we are going to be moving quickly on PACS.

And to your question of when we are going to take the next step—just as soon as possible.

Chairman HEINZ. Will that be this year?

Dr. ROPER. We have a team of people looking at the recommendations right now——

Chairman HEINZ. Let me tell you why I am concerned——

Dr. ROPER [continuing]. If I could just answer—implementation of a number of the IOM recommendations require changes in law at the State level, some at the Federal level. It will be done as quickly as possible. We do not want to wait.

Chairman HEINZ. My concern—and Senator Cohen touched on it in his remarks—is that we first mandated the development of a PACS kind of approach back in the mid-1960's, and here it is almost halfway through 1986. That is about 20 years.[8]

Now, the reason I am pressing you on how quickly you are going to act on the study that you yourself—yourselves—you were not there at the time, but the Department—commissioned is that we do not want to wait another 20 years.

Can you give us any assurance that you will be able to come to grips with the findings and make decisions—whether or not you have the power to implement is one thing; Congress may have to be helpful to you—but can you say to us that you will come to conclusions within 6 months or a year?

What can you say to us?

Dr. ROPER. I understand the urgency in your question, sir, and I just want to tell you that I have that same urgency. I hesitate to make a commitment because something I have not personally focused on is what the time frame is, but I am told that we are doing it very quickly.

Chairman HEINZ. How soon will you be able to tell us how long it will take you?

Dr. ROPER. I would think within a month or two, something like that, yes, sir.

Chairman HEINZ. All right. Do you mind if we hold you to that?

Dr. ROPER. I would be glad to respond to you, sir.

Chairman HEINZ. You are learning fast. [Laughter.]

One other reason I am kind of impatient on this is that this committee—and you touched on this in your statement—has been told twice before that intermediate sanction regulations would be released soon.[9] That law was passed in 1980. And in your remarks, you say that you are about to come forward with them.

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[8] See appendix 4, p. 818 for *Smith* v. *Bowen* documents.

[9] "Please see volume II, appendix 6, letter to DHHS Secretary Heckler dated 12/16/83, letter to Senator Heinz dated 1/12/84, and letter to DHHS Under Secetary Baker dated 11/13/84."

That is really going to happen, is it?

Dr. ROPER. Yes, sir.

Chairman HEINZ. My time has expired.

Senator Pryor.

Senator PRYOR. I do not even know where to start, Mr. Chairman. I have got several questions. But I think first, rather than a question, Dr. Roper, I just have a suggestion.

I think that if I were you, in your spot at this time—and I know it is a difficult position—I think if I were you that on Monday morning—that is Memorial Day, so Tuesday morning of next week—I would invite and strongly encourage all of the 50 States to have a representative not only from their nursing home industry—and I use that word again—here in Washington to meet with you, but also the head person or the officer in charge of, let us say, the Department of Human Services on the local level that has jurisdiction over this issue. And if I were you, I would read them the riot act, and I would tell them that the Congress is going to respond to this report—we are going to respond to this report—and the only way we are going to get this thing straightened out is for them to know what the rules are and how serious we are about coming out of this thicket. And we are in a thicket. We are in a bureaucratic thicket.

I was just wishing today, Mr. Chairman, that we might have had some sort of a diagram to show this jungle of bureaucracy where somewhere down at the very end, there is that poor patient, who does not understand it, a jungle of bureaucracy that includes the Federal Government, the State government, the local government, Medicaid, and Medicare, the VA, the HUD people, the HCFA people, the State inspectors—and all across the land, this bureaucracy is an absolute nightmare.

Let me ask you this question. Who is in charge? Who is in charge and who is responsible for this?

Dr. ROPER. HCFA is responsible. The States are also responsible. And I understand your concern that we work together effectively, Senator, but that is happening. The thing that I would point out to you is—although I have not yet had a chance to see the report that the committee has prepared—the fact that your surveyors have found increased numbers of violations may mean that people are being more aggressive in identifying violations. And what we need to take a careful look at is whether the problem is getting worse, or whether we are doing a more aggressive job of looking for problems.

The real question that follows from that is, What is the Federal Government going to do about it, and then what are the States going to do about it?

Senator PRYOR. Does HCFA have the power to do anything about it?

Dr. ROPER. Yes, sir.

Senator PRYOR. On its own?

Dr. ROPER. Yes, sir.

Senator PRYOR. Can HCFA make a decision and override a State body in this area?

Dr. ROPER. That is what the look behind process is all about, yes, sir, and we have been doing that for 2 years now.

Senator PRYOR. Do you plan to do this?

Dr. ROPER. Yes. We plan to continue to do it, and it has been done, as I said, for years now.

Senator PRYOR. What sanctions are you going to recommend if a nursing home is in violation and continues to be in violation?

Dr. ROPER. Well, the sanctions that have been available and will continue to be are the ultimate sanction of cutting off payment for patients.

Intermediate sanctions that will very shortly be available will be less severe, such as stopping new payment for new patients in such a nursing home. We have control of the purse, and that is a great deal of leverage.

Senator PRYOR. But if you choose the sanction of did you say cutting off the payments for the patient——

Dr. ROPER. Yes, sir.

Senator PRYOR. Then what happens to the patient?

Dr. ROPER. If we cut off payment totally to all Medicare and Medicaid patients in a nursing home, then they have to be moved to another facility.

Senator PRYOR. And where are those facilities?

Dr. ROPER. In that same local area is the best place. But you point out a real problem——

Senator PRYOR. Is there not a shortage of facilities and beds at this time?

Dr. ROPER. In many areas, there are, yes, sir. That is why it is important not simply to go in with heavyhanded sanctions if we can work in a way that improves the care that is being given so that patients can continue to be cared for; that is much better.

Senator PRYOR. Well, my time is up, Mr. Chairman.

Dr. ROPER. You look as though you did not hear me.

Senator PRYOR. Well, I am pretty astounded that one of the sanctions you are considering is—where have I missed a step here? How could you cut off the payments to the patients when they are not at fault?

Dr. ROPER. No; I have not said cut off payments to the patient. I said cut off payments to the nursing home——

Senator PRYOR. For that particular patient.

Dr. ROPER. Right.

Senator PRYOR. And suddenly, that patient has no bed the next day.

Dr. ROPER. The ultimate leverage we have is the money that is paid from public programs to the facility; yes, sir.

Senator PRYOR. I think we have got a long way to go here. And my time is up, Mr. Chairman. Thank you.

Chairman HEINZ. Senator Pryor, thank you.

Senator Chiles.

Senator CHILES. I listened again to your saying the question now becomes what are we in Congress going to do about it? You know, I kind of think the question should be why haven't you done something about it?

We are talking about a 2-year study that is done by the committee. Those facts are not secret, the facts that the committee had, the facts of the abuse. Certainly, HCFA knows about that. The committee staff got them from the records you require. That is where they got their information from.

So the question, rather than what do we do about it, now, like this has suddenly appeared—the question is, What have you done about it?

Dr. **Roper**. Senator, I——

Senator **Chiles**. Why haven't you done anything about it?

Dr. **Roper**. OK. Thank you for your question.

Again, I have not seen the study yet, but I have explained to you a number of steps that have been taken over the previous years and some of the things that are about to be done additionally.

The issue at hand is what can be done to improve the quality of care in nursing homes, and I think we have made substantial progress already.

Senator **Chiles**. Well, a couple of years ago we know the administration was planning to issue new regulations regarding nursing home survey and certification rules.[10] At that time, there was a lot of fear that loosening those standards could cause us to have a problem. I do not think we realized how big the problem was at that time. But the Appropriations Committee, as a result of the action taken by some of us, blocked your issuing those looser standards and required further study before you could lower the quality of care and loosen those standards.

I understand the Institute of Medicine has subsequently undertaken such a study and issued their report. I have not studied their report, but I know that they also were quite critical of your current methods of enforcing quality of care.

So, if we were not enforcing what we had, and then you were proposing over the last 2 years to loosen the certification requirements, and now you are saying, "Well, we have been working on this for a couple of years," it seems to me you were working to loosen what was not working to start with; that you were going to make it more lax.

Dr. **Roper**. No, sir. We are working to enhance the control and to tighten enforcement to make sure that substandard homes are taken out of business.

Senator **Chiles**. Well, have you used your ultimate authority?

Dr. **Roper**. Yes, sir.

Senator **Chiles**. Have you withheld the payments from anybody? Have you shut down somebody? Have you——

Dr. **Roper**. Yes. I mentioned that in my testimony.

Last year, 130 skilled nursing facilities, 108 intermediate care facilities.

Senator **Chiles**. Well, are you delaying payments to nursing homes the same way you are now delaying payments in Medicare coverage?[11]

Dr. **Roper**. No, sir.

Senator **Chiles**. Well, Mr. Chairman, I am holding a hearing as you know under the Aging Committee in Jacksonville on Friday. What we have been told is that HCFA has gone from what was 9 days in payment of claims—or, this is the testimony I am getting from Florida; I do not know whether it is true nationwide—to now 18 days, and they have now issued instructions that they want a 30-day float.

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[10] Please see Federal Register dated 5/27/82, page 23404.

[11] Please see 5/23/86 Hearing of Special Committee on Aging, Serial No. 99-20.

HCFA says this is good business practice, that most people do not pay their bills within 30 days; but because of this we are now talking about up to 60 days for people getting their doctor bills paid.

Obviously, what is happening in my State is that those doctors that were taking assignment are saying, "We are not going to take it now." So they are failing to take assignment, which makes it 10 times worse on the Medicare recipients. I sense that some of this is happening here too, that part of our problem here is that we are going to delay payments; as some kind of bookkeeping savings or something.

We are going to wind up the end of this year, I think, with $2.3 billion in Medicare claims unpaid. I do not know what it will be next year, but probably a doubling of that, because it will go to a 30-day payment cycle. So we are building a bubble, or balloon with these unpaid claims. Some day, those bill have got to be paid.

I do not know how long we can go along ignoring this delaying process, but I sense that part of our problem here may be just part of the bookkeeping thing of "let us just delay people awhile"——

Dr. **Roper**. Senator, I understand your concern about payment rate under Medicare. Since nursing homes are predominantly Medicaid payments, another program, States direct the Medicaid Programs, and that is not affected by the change in payment timetable.

Senator **Chiles**. My time is up.

Chairman **Heinz**. Senator Chiles, thank you.

Senator Cohen.

Senator **Cohen**. Thank you, Mr. Chairman.

Let me say, Mr. Roper, that I am impressed with your professional qualifications, and also your commitment based upon your own personal experience with your mother.

Part of the difficulty that I have with this whole process of us being up here and you down there is that there is such turbulence within the administration that I have what Senator Heinz mentioned as deja vu. I have the feeling that I am in a penny arcade, trying to shoot a target, and every time I zero in on a target, the target keeps getting changed.

Now, my understanding is we have had one permanent Administrator of HCFA under the Reagan administration, we have had two Acting Administrators, and then you. And I do not know how long you intend to be there, but one of the problems that with Congress and how it operates is that most administrations understand that we have a very short attention span. If you just delay long enough, we will be onto some other issue, or there will be a congressional recess, or elections, or tax reform will intervene, or the budget debate will subordinate all other interests, and pretty soon we have a new Congress, and they have got to start all over again.

Now, that has been part of the process since my experience——

Chairman **Heinz**. Senator Cohen, you are giving him the secrets of his trade. He has only been here 2 weeks. It would normally take him a couple more weeks to learn all of that. [Laughter.]

Senator **Cohen**. Senator, believe me, those who are not here today have already advised the Administrator about the process.

Dr. **Roper**. For better or for worse, you have got me for a long time to come.

Senator **Cohen**. Well, I hope we have you. I was particularly concerned about Senator Heinz trying to pin you down about when we can expect some sort of formal notification as to what the time line is going to be. We have been strung out on this issue at least since 1973, maybe as early as 1970. We are getting impatient and I think the time is coming where the issue will reach crisis proportions. We are getting impatient and are going to demand more and more in the way of action.

You are learning fast, according to Senator Heinz. I would make one other recommendation and that is to submit your testimony on time and not wait until the evening before so that we will have more of an opportunity to review it in some detail.

Now, you stated that the termination from the Medicare/Medicaid Program is a last resort. Are there any sort of intermediate solutions or sanctions currently applied to individual nursing home operators? For example, how about the imposition of fines? Why be just forced, as Senator Pryor has said—to terminate the reimbursement to the institution, which effectively means you are throwing that patient out of the nursing home out into the street or into someone's home? Why not really hit the institutions where it hurts, by imposing a fine?

Dr. **Roper**. I am not aware that that is permitted, but the intermediate sanction that many States have been implementing for some time now and that we shortly will be implementing under the Federal regulations is to say that we will continue paying for patients currently in that nursing home, but we will not allow new patients to be admitted, and we will not pay for new patients. That is a sanction.

Senator **Cohen**. That leaves you with the same leverage as they have now—they have the same leverage; they can continue with their existing patients and not allow any additional ones in. It really does not hit them that hard. Why not impose fines upon those institutions which are in fairly clear or indeed, flagrant violation?

Dr. **Roper**. That is surely something to look at, Senator.

Senator **Cohen**. But why does it take some time to look at it? Isn't the imposition of fines a reasonable proposition to make in a situation like this, where an institution is getting the benefit of Federal funds and abusing those funds, in essence?

Dr. **Roper**. It sounds reasonable on its face. I would be glad to take a look at it.

Senator **Cohen**. You also stated in your prepared testimony that surveyors can make additional unannounced visits between those of the regular announced ones; is that right?

Dr. **Roper**. Yes, sir.

Senator **Cohen**. Are there any requirements for unannounced visits?

Dr. **Roper**. Yes, they are required to do that.

Senator **Cohen**. They are required to do that?

Dr. **Roper**. Yes, sir.

Senator **Cohen**. That is all I have.

Chairman **Heinz**. Senator Cohen, thank you.

Senator Pressler.

Senator **Pressler**. Thank you.

I would like to say that the nursing homes that I visit in my State, I usually find in very good shape. I am very impressed with the quality of people who work in them. If there are problems, it seems that the State administrators blame the Federal Government, and they say their rules are adopted pursuant to Federal regulations.

I suppose the tone of what this committee is saying is that maybe we need more Federal requirements to meet some of the needs.

First of all, is there a distinct difference in the quality of care regionally or State-by-State throughout the country?

Dr. **Roper**. I do not think there is, Senator, but I have not looked at that personally. I would be glad to do that.

Senator **Pressler**. I would very much like to submit for the record, a question to you. I know that there are some distinctions in the Aging Committee staff report among States percentagewise, but I would like to, in particular, compare my State of South Dakota to some others so I can learn more about this problem; if for the record you could submit anything you have or your staff has.

Dr. **Roper**. Yes.

[Information follows:]

We are unable to provide any additional information on the reported findings of the Senate Aging Committee on their allegations of substandard care in nursing homes because HCFA did not compile the data upon which the findings are based. Since we do not know the parameters that were used in generating the data, for example, the dates of the surveys, we cannot identify the facilities involved. In addition, going back in time to reconstruct the data is impossible since the system has been updated with more recent survey information. Such updated information overlays earlier survey data, thereby eliminating the earlier data from our computer system.

The survey and certification process for nursing homes involves the inspection of a large number of facets of care provided to residents. Judging "quality of care" must involve review of the entire findings of a skilled nursing facility's compliance with the more than 500 standards and requirements for participation under the Medicare and Medicaid program. HCFA data on the compliance status of nursing homes does not indicate significant variations either regionally or State-by-State.[12]

Senator **Pressler**. Well, let me ask you, from your personal point of view, based on the tone of this hearing, does it seem to you that we are asking for more Federal regulations, or do you feel that it is just enforcement of existing State or Federal regulations?

Where is the weak point?

Dr. **Roper**. What you are saying is that you want quality care given to residents of nursing homes. You have developed some data that say over time, there have been additional violations of standards found.

A point I made in answer to Senator Pryor's question is what I need to look at is whether that is a result of things getting worse, or whether it means that the surveyors, the people going into the nursing homes, are being tougher and are giving more traffic tickets, in effect. What we really want over time is things to get better. I need to look at the study and decide what kind of recommendations to make to you as to what ought to be done.

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[12] Please see volume I, page 390, and printouts in appendix 3, beginning page 514; see also volume II, pages 78 and 887.

Senator PRESSLER. Well, I certainly want to wish you well in your new job. I sense that you are going to do an excellent job, I think we are lucky to have you, and I hope you stick with it.

From time to time, I hope you tell us where you think the problems lie—because when I go into a nursing home I am told, "Well, we are so confused because we do not know exactly what the rule or regulation is;" another will tell me, "We wish we had more local autonomy." It seems as though without the Federal regulations, there are abuses—this becomes a very difficult situation. And some people say, "well, if the Federal Government makes a rule, they should pay for it." And I am one who prefers that things be done on a State level. But, the fact of the matter is that frequently, if that is done, there are abuses in many States.

So sorting all this out, I think, is a major problem that this committee and that you face.

Thank you.

Chairman HEINZ. Senator Pressler, thank you.

Senator Jeff Bingaman, of New Mexico.

STATEMENT OF SENATOR JEFF BINGAMAN

Senator BINGAMAN. Thank you, Mr. Chairman.

Chairman HEINZ. Senator Bingaman, do you have any opening remarks?

Senator BINGAMAN. I do have an opening statement, which I will put in the record, and I will just refer to it if I could.

Chairman HEINZ. Without objection, your entire statement will appear in the record.

[The prepared statement of Senator Bingaman follows:]

PREPARED STATEMENT OF SENATOR JEFF BINGAMAN

Mr. Chairman, I wish to commend you and the ranking minority member, Senator John Glenn, for holding this hearing today. This hearing is an excellent opportunity to bring forth some of the quality of care problems that plague residents in nursing homes. I welcome the testimony of the witnesses in clarifying some of these problems.

Today's hearing is a follow up to the series of PPS quality of care hearings held last fall by the Committee as well as to earlier committee hearings on nursing home care in October 1984, February 1983, and July 1982. Investigations and hearings held last year on how quality of care in Medicare is impacted by the prospective payment system (PPS) found that the number of patients discharged from hospital care and into nursing homes is increasing. Furthermore, because of PPS incentives to move patients out of hospitals in an expeditious manner, discharge planning for many of these patients is inadequate and rushed. As a result, nursing home care for these persons may be inappropriate and/or substandard.

Recently, this Committee's investigations have found that: (1) there are many repeat offenders in the number of nursing homes that provide substandard care; (2) there are serious inadequacies in care, including abuse and neglect; (3) federal and state enforcement mechanisms are often inadequate and cannot ensure quality care; and (4) consumers have a difficult time in finding quality nursing homes.

Testimony at the Committee's hearing last November disclosed that the Health Care Financing Administration (HCFA) relies on state survey and certification contractors to ascertain whether or not nursing homes provide quality care.

In New Mexico we are very fortunate because we do not have any glaring problems with quality of care in our nursing homes. This is the consensus of providers, regulatory personnel, and ombudsmen. In New Mexico we have 64 facilities that offer intermediate care (ICF) with 18 facilities offering skilled care (SNF). Sixty-one of these facilities receive federal funding while only three are licensed facilities.

This is not to say that we don't have any problems. One of our biggest problems is that New Mexico has a very weak and outdated code of state nursing home regulations. New Mexico also lacks a residents' bill of rights. The New Mexico regulations were promulgated in the early 1970's and do not reflect the current quality of care given to residents. Rather, they emphasize building code compliance which was the big issue at the time of their implementation. The state regulations are presently undergoing review and will eventually be rewritten, but progress has been slow. Until that time, however, the federal regulations are relied on to ensure and/or enforce quality of care. Therefore, I am told by New Mexicans that there is cautious optimism regarding the new patient-oriented federal long term care survey process.

Another area of concern in New Mexico is the high cost of skilled care. Currently, the cost of skilled beds is $85.00 per day. This is the third highest figure in the nation, outranked only by Alaska and New York.

Furthermore, the funding for our ombudsman program is also low. Recent figures show that we are 45th in terms of state funding when compared to all states; 46th in local funding; and 49th total funding nationwide. This affects our ability to regulate and ensure that residents are receiving the best care possible.

Like many other states, consumers in New Mexico experience difficulty in finding a quality nursing home. The ombudsman office has brochures and maintains a list of facilities in the state. But many consumers don't know of this service and therefore don't utilize it. Consumers are often unaware of the fact that facility inspection reports are accessible at local Social Security offices. These two avenues are the only formal means available to assist consumers in selecting a nursing home facility. Otherwise consumers are left on their own. Oftentimes, the main criteria in selection of a nursing home ends up being proximity of the nursing home to the resident's family.

There are some other problems with nursing homes in New Mexico. I have just enumerated a few of the major concerns.

Thank you, Mr. Chairman.

Senator BINGAMAN. Let me just ask in response to the question that Senator Cohen asked about unannounced visits, you said that there is a requirement that there be unannounced visits. The requirement is by regulation, is that correct?

Dr. ROPER. That is my understanding, yes, sir.

Senator BINGAMAN. Do you know the number of unannounced visits that are required?

Dr. ROPER. No, sir, but I will be glad to get that answer for you.

Senator BINGAMAN. Do you have any idea of the extent of the number of unannounced visits that do regularly occur that HCFA conducts?

Dr. ROPER. The ones we conduct are the so-called look behind visits—and let me get that number for you—in 1985, we performed 464 look behind surveys; it will be 800 this year.

Senator BINGAMAN. But those were not unannounced, were they? I thought a look behind survey was different from an unannounced visit. The unannounced visits are done at the State level; is that correct?

Dr. ROPER. Yes, sir.

Senator BINGAMAN. And you do not have any statistics on the extent of those by State?

Dr. ROPER. I am sure we have the statistics, and I will be glad to provide them for you.

Senator BINGAMAN. OK. That would be very helpful.

[Information follows:]

Currently there are 17,892 long-term care facilities requiring an annual survey. Attached is a chart listing the number of facilities by State.

LONG TERM CARE FACILITIES BY STATE AS OF MAY 16, 1986

STATE	SNFs	ICFs	ICFs/MR	TOTALS
AK	9	2	4	15
AL	193	18	8	219
AR	159	100	8	267
AZ	61	0	0	61
CA	1167	38	172	1377
CO	164	29	11	204
CT	197	35	88	320
DE	27	8	9	44
FL	427	4	69	500
GA	283	41	11	335
HI	27	9	7	43
IA	40	411	17	468
ID	60	2	16	78
IL	467	269	87	823
IN	203	335	194	732
KS	71	310	24	405
KY	94	122	9	225
LA	38	251	164	453
MA	305	218	38	561
MD	114	79	9	202
ME	18	125	40	183
MI	300	137	230	667
MN	372	146	360	878
MO	243	121	22	386
MS	134	21	13	168
MT	85	11	3	99
NB	42	178	4	224
NC	178	52	37	267
ND	59	23	23	105
NH	22	49	15	86
NJ	252	15	11	278
NM	16	52	13	81
NV	26	3	3	32
NY	562	38	659	1259
OH	454	498	213	1165
OK	18	356	15	389
OR	67	113	10	190
PA	583	116	117	816
RI	66	40	93	199
SC	103	29	48	180
SD	68	46	18	132
TN	87	170	19	276
TX	265	781	180	1226
UT	45	33	11	89
VA	83	98	17	198
VT	20	25	14	59
WA	249	30	38	317
WI	387	62	32	481
WV	40	56	5	101
WY	23	6	0	29
	8,973	5,711	3,208	17,892

Senator **Bingaman**. Let me ask about this issue of swing beds. You have not had a chance to see this staff report that has been prepared; is that right?

Dr. **Roper**. That is correct.

Senator **Bingaman**. I understand that there is authority for the use of hospital beds to augment what is available for nursing homes where that is needed; is that your understanding?

Dr. **Roper**. Yes, sir, in particular in rural areas where at times you need acute hospital beds, and at other times you need nursing home beds.

Senator **Bingaman**. To what extent is the Swing-Bed Program being used now?

Dr. **Roper**. It is actively being used. Again, I do not have numbers, but I would be glad to provide them for you.

[The information follows:]

There are currently 805 hospitals approved for swing-bed participation. These hospitals have a total of 31,622 beds that may be used for long term or nursing home care.

Senator **Bingaman**. Is it your thought that it needs to be expanded, the use of hospital beds?

Dr. **Roper**. That the swing-bed provision needs to be expanded?

Senator **Bingaman**. Well, does HCFA need to do more to provide hospital beds to take up the slack or to take up the demand?

Dr. **Roper**. I am not sure I understand your question, but if you are saying should we—well, again, I had better just say I am not sure I understand your question.

Senator **Bingaman**. Well, it says here that—I gather there is a shortage of beds in some areas in nursing homes.

Dr. **Roper**. That is correct.

Senator **Bingaman**. It says here there are 148,000 excess hospital beds in the United States. The Inspector General argues [13] that if we were to use these existing beds as swing beds, we could avoid building a great many of the nursing home facilities that otherwise would be required. I guess I am just asking if you agree with the Inspector's position that we should expand the use of hospital beds as swing beds.

Dr. **Roper**. That makes good sense; yes, sir.

Senator **Bingaman**. The staff recommendations in this report, which you have not seen yet, list a whole series of recommendations which should be done either by Federal legislation or improved regulation.

If someone has not already asked, maybe you could provide for the record, once you get a chance to review those recommendations, which of them you believe would require new legislation and which ones you believe you could handle as the Administrator of HCFA.

Dr. **Roper**. I will be glad to do that; yes, sir.

Senator **Bingaman**. OK.

[Information follows:]

I am now reviewing our recommendations on the Institute of Medicine's [IOM] study and will be forwarding them to the Secretary very shortly. After the Secretary's review and approval, I hope to share with you our plans for making any needed changes in the Federal Medicare/Medicaid requirements which govern nursing homes.

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[13] Please see volume II, appendix 6, beginning page 681.

Senator BINGAMAN. That is really all I had, Mr. Chairman. Thank you.

Chairman HEINZ. Senator Bingaman, thank you very much.

I am going to ask just one more question—and if any other members have further questions, I will be happy to have Dr. Roper entertain them—but it is this. According to the analysis that the staff has done—and here are the printouts—about 1,100 feet of printouts of violations of not just the trivial standards among the 540-some-odd conditions of participation in the critical standards, but of the 25 most critical standards, there are 9 of them up there on the right, what they found is that of about 8,800 skilled nursing facilities, 3,000 have been violating 1 standard in the last 12 months or so; some 1,000 have violated 3 of these 25 critical standards, some of which are up there, at any one time during the last year; and then, in 3 out of the last 4 inspections, some 600 nursing homes have violated 3 or more of those critical standards. And I have called those grossly substandard, chronically substandard nursing homes.

Now, those inspections take place over several years in the case of those chronically substandard homes, so my question is this. One, as you look at the data up there on that chart, which shows that violations appear to be significantly increasing, you can say, "Well, some of it is better enforcement," but I doubt that our enforcement procedures are 100 percent better in just 2 years—that is asking a lot—or 75 percent—but they might be 20 percent better. But you cannot say that that is all just, you know, well, we are more meticulous and we have whiter gloves.

And second, we have got a very substantial portion of nursing homes, some 600—maybe 900, depending on how you want to count them—of 8,800 being year after year chronically substandard.

What is the problem? Why is this taking place?

I am glad you are moving to a patient-oriented evaluation system, but what is going on right now? Why do we seem to be falling down on the job? Is it Congress' fault? Is it your fault? Is it the States' fault? Where is the fault?

Dr. ROPER. You have asked the central question, sir. I think that my answer has to be that I want to look at your report, study the data, come up with any recommendations that we feel are warranted out of there, because as I said in my statement, we want quality care, and I know you do, and I want to work with you.

Chairman HEINZ. Well, although you are new at HCFA, you are not new to the enforcement of nursing home standards. You were in Alabama for a considerable period of time. And so you are not inexperienced in these matters.

Dr. ROPER. Yes, sir.

Chairman HEINZ. Now, even though at this point you have only been on the job for a couple of weeks, based on your experience, based on your professional training and knowledge, what would you think is the problem?

Dr. ROPER. I think a key part of the problem is we are groping for how to measure quality. We have in the past focused largely on how many of a given kind of staff there are in a facility, how many reports are generated, those kinds of things. We are coming now, finally, to look at whether quality care is being given, and I think once that is in hand, we can begin enforcing it.

Chairman HEINZ. Let us just examine that a little bit, Dr. Roper. We do have 541 standards, and maybe some of them are groping for something, but in a skilled nursing facility where they are failing to provide adequate 24-hour nursing care, what you are talking about is having a nurse on call in the middle of the night when your mother or father has a chest pain and may be experiencing a heart attack or may be having a stroke, or may be having a seizure or may be having kidney failure. I mean, that is pretty down to earth, understandable, quality of care. And according to the analysis, the incidence of failing to meet that minimum standard has gotten 61 percent worse in the period 1982 to 1984. Now, that is not groping, unless you are the patient. Then you are groping for the button, you press it, and maybe nobody comes.

A comment? And the question is why is that happening. Who is falling down on the job?

Dr. ROPER. I think there is no question, Senator, that there are substandard nursing homes in America. Our data has shown that; your data appears to show that. What I hope to do is aggressively manage the program to make sure that that improves.

Chairman HEINZ. Well, my time has expired.

Are there any other questions from the committee?

Senator Pryor.

Senator PRYOR. Is it Bill Cohen's time, or mine?

Chairman HEINZ. It is yours, and then Bill's, and then Senator Pressler's.

Senator PRYOR. Dr. Roper, years ago when I was a Congressman—I was pretty anonymous—and still am—I went out and worked in 11 nursing homes as an orderly on the weekends. It was quite a revealing experience for me and, I must say, very educational. I got to the point where I could not find any facts out from the bureaucracy, so I sort of went out there on my own, and I got caught up in this issue.

One thing that I heard over and over again during that period was that these, "unannounced visits" were not unannounced; that the nursing home owners were tipped off before these visits occurred, sometimes as much as 2 days in advance. We even found evidence of this in my State. And I must say, Mr. Chairman, when I heard last night that my State, Arkansas, was third on the list for chronically substandard facilities, it really concerned me a great deal

What evidence are you finding today that these visits are not truly unannounced and that the nursing home owners or operators have advance warning before these people come in—these inspectors?

Dr. ROPER. Senator, that is something I have not had a chance to look into, but I surely will. Obviously, as your question indicates, what we want to make sure is that the quality is there, day in and day out, not just when the inspector is scheduled to come.

Senator PRYOR. I hope, too, that you will do something else on the inspection issue—and I do not know whether you are doing it or not. A nursing home during the day is very different from a nursing home during the evening. I would suggest that when inspections are made that they be made during the evening.

Dr. ROPER. That is a good suggestion.

Senator PRYOR. Because it is a different place entirely. The number of personnel usually is less. Doctors are not on duty as much, and their presence, of course, is somewhat insubstantial, I think. But I hope you will consider that as a suggestion.

Chairman HEINZ. Thank you, Senator Pryor.

Any other questions?

Senator Cohen.

Senator COHEN. Just a comment to follow up on what Senator Pryor was saying. I would point out that the quality of the Senate debates are quite different in the late night and early morning hours than they are during the middle part of the day. It is my hope—and I say this not in jest—that the presence of television cameras will change, at least moderate and perhaps unify, the quality of debate during the course of the day and night. I say that with a note of seriousness, because I think it will have exactly that effect.

What Senator Pryor is saying is that we want the same sort of critical scrutiny being applied by HCFA to the quality of care that is being administered at night that is applied during the day.

I only want to make one other observation. The violations that have been listed on the board happen to deal with medical treatment for the most part. That is of critical importance. But of equal importance to me is that patients are not being treated with respect. There are patients being treated as being incapable of making choices about things as simple as what to wear, when to wake up, who to see, whether they can control their own bank accounts—things that each of us would demand as ordinary human beings. They are then being deprived of those guarantees and rights, in many instances, when they go into a nursing home.

So I would put the quality of treatment of those individuals as human beings almost on the same level of parity with medical treatment. In my judgment, that has been neglected and not focused upon at all by HCFA or anybody else. The quality of medical care is important, but the quality of treatment in terms of how the patients function as human beings is also important. I would hope that you would focus upon that as well.

Dr. ROPER. Yes, sir. Thank you.

Chairman HEINZ. Senator Cohen, thank you.

Any other questions?

[Pause.]

Chairman HEINZ. If not, Dr. Roper, I have some additional questions that I want to submit to you.[14] You are going to be very busy answering all of our questions.

Again, we welcome you to life in Washington, DC.

Dr. ROPER. It is a pleasure to be here, Senator.

Chairman HEINZ. You may have preferred it in Alabama after you get through answering the questions. And we will probably want to have you back before the committee in a month or two to see how you have done on the Institute of Medicine study because, as Senator Cohen points out, we know that you know about our short attention span, so we are going to have to overcome your perceptions about our short attention span.

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[14] See appendix 1, p. 278 for correspondence between the Special Committee on Aging and DHHS.

Dr. ROPER. Yes, sir.

Chairman HEINZ. Thank you very much.

Senator PRYOR. Mr. Chairman, I hope Dr. Roper will remember that he, like all of us, is a potential candidate to be a patient in a nursing home, eventually. That might spur him on to get to the bottom of this problem. I appreciate your comments.

Chairman HEINZ. Thank you, Dr. Roper.

Dr. ROPER. Thank you, Senator.

Chairman HEINZ. I would like to ask our next panel to come forward: Dorothy Doyle, of Alpharetta, GA; Peggy Dowling, of Napa, CA; Ralph Lopez, of Los Angeles, CA; Sandra Casper, of Madison, WI; Conrad Thompson, of Olympia, WA, and Toby Edelman, of Washington, DC.

As our witnesses are seating themselves, let me observe that our second panel here includes a total of six witnesses who have learned a great deal about the real world of chronically substandard nursing homes.

On behalf of the committee, I welcome each of you here today, and we very much appreciate your taking time away from your families, from your responsibilities, your jobs, to share with us your experiences and suggestions on how we can, indeed how we must, improve the quality of care in nursing homes.

The first two witnesses, Ms. Doyle and Ms. Dowling, are here to tell us about some of their own personal experiences. I understand that they were not very pleasant experiences, and we are sorry to have to ask you to do that, but I think it will be of help to the committee.

Mr. Lopez is chief of the health facilities division of the county department of health services in Los Angeles.

Ms. Casper is the president of the Rehabilitation Care Consultants in Madison; and Conrad Thompson is the director of the Washington State Bureau of Nursing Home Affairs.

Ms. Toby Edelman is a staff attorney for the National Senior Citizens Law Center here in Washington.

You have each submitted prepared testimony, all of which will be made a full part of the hearing record.

Let me start with Ms. Doyle who comes to us as I mentioned from Alpharetta, GA. Ms. Doyle, thank you very much for coming here. I know your two Senators, were they on this committee, Senator Mattingly and Senator Nunn, would want me to welcome you in their behalf, and I so do.

Please proceed.

STATEMENT OF DOROTHY A. DOYLE, ALPHARETTA, GA

Ms. DOYLE. My mother had Alzheimer's disease and entered the first of three nursing homes in 1980 at the age of 70. Though we were Florida residents, and I was her caregiver, I placed mom in an intermediate care home near relatives in Georgia, because Florida Medicaid assistance at the time refused Alzheimer's patients.

Mom's care there was average, but my family was upset to find that she was tied to a chair from the time that she entered. The staff said this was for her safety.

The first Medicaid cuts resulted in a dramatic drop in the quality of mom's care. She was hospitalized with a severe infection and lost continence, along with the ability to walk, talk, and use her hands. She required an indwelling catheter.

Mom's doctor advised me that from that point, the length of my mother's life would depend entirely upon the quality of her nursing care.

I decided to move mom back to Florida, near me, where I could better monitor her care. The only bed I could find was in a home that did not accept Medicaid. About a year later, the nursing home decided for the first time to participate in the Medicaid Program. Those patients going on Medicaid were moved to another area of the home. The administrator changed, and troubles began.

The quality of mom's care went down. Her contracted hand was neglected to the point where she required surgery in order to prevent its amputation. An adequate supply of clean clothing became impossible. Shortly after one of my complaints, I found mom in bed clothed only in an undershirt, all of her clothing was dirty and a note was on her drawer saying mom's laundry was not to be done.

When I asked the administrator what was happening, he responded by shouting, "Take your mother and get out. I am sick of ungrateful deadbeats like you. Both of you get out."

He terrified me, raving, shaking his arms, pounding the wall, repeating that no matter how much he did for people like us, we did not appreciate it.

I reported the incident to Medicaid's investigative unit. Medicaid notified the home that it had 30 days to remedy violations or lose funding. Management responded by notifying all Medicaid patients they were no longer welcome.

Efforts to find mom another Medicaid bed in south Florida were unsuccessful. I no longer had the resources to "buy" mom's way into a decent home. I rejected the choice to move my helpless mother, alone, to another area of the State.

Though we had only a contingent contract on the sale of our house, we risked moving before our closing date in order to accept a Medicaid opening in what seemed an average Atlanta area nursing home.

Mom's care was average, at first. Then, except for a couple of months in the fall of 1984, it steadily declined. Mom developed another severe infection and seizure that December. The crisis passed, but for reasons unknown, her temperature went up and down, yet never left.

I found mom, elevated temperature or not, always in bed; yet only once did I ever see a turning chart. She was not given ample fluids, and her fluid intake-output chart was neglected. Needed medication was not ordered. She was not bathed. Her hair smelled. Her clothing and linen were dirty. Her room was never clean, and her furniture was covered with dried food.

The shrinking staff became indifferent and defensive. Occasionally on evening visits, I found no staff at all.

Seldom able to find linens, I began carrying Handi-Wipes to bathe mom. I dried her most times with paper towels. And then the fly infestation began. They were on her face, in her sores, on her food. Visiting my mother became a horror that left me either nauseated or in tears or both.

I had to force myself to go back for the next visit. I complained to supervision, but nothing changed. I tried to move mom out, but no nursing home would accept Medicaid without my first paying for her care for a specified number of years.

With no place to move mom, I would not chance complaining to the State. I began praying God would let my mother die.

Deeply distressed, with heavy responsibilities and limited available funds, I decided to hire a private nursing aide. It was then, when I assisted in preparing mom for her first whirlpool bath, that I found the unexplainable cause of mom's persistent temperature. My mother's lower extremities were covered with open, running, infected ulcers.

With care from the private aide, my mother's condition improved steadily. In 6 weeks, her sores were healing nicely, and her temperature was gone.

The nursing home, however, continued to be filthy and staff care poor. At the end of July 1985, my mother developed pneumonia and died.

In February this year, after a massive investigation involving the State attorney general's office, the nursing home lost its Medicaid certification due to poor infection control and conditions that posed a threat to the health and safety of patients.

Three of its employees were arrested for patient abuse. The owner, a man owning 17 nursing homes, appealed. I was one of the State witnesses for his hearing. No family members ever testified, because the State struck a deal with the owner, whereby he dropped his appeal and accepted a 120-day loss of certification. He is the same man who recently paid $525,000 to have the State drop a 1982 suit for $1 million in Medicaid nursing home overcharges.

Though it is against the law to do so, one witness, an employee of the home, was fired the day after the settlement.

Several of us who were State witnesses are pressing for further action and changes in policy. So much more needs to be done. We have reached a point in the graying of America where we can no longer leave this to tomorrow. The cost of extended nursing home care is out of reach for all but the wealthy, and we are next at the nursing home door.

[The prepared statement of Mrs. Doyle follows:]

1125 Pine Grove Drive
Alpharetta, Georgia 30201
May 13, 1986

Senate Special Committee on Aging
U. S. Senate, Room SD-G33
Washington, DC 20510

Gentlemen:

I am grateful for the opportunity to tell you of my experiences regarding my mother's nursing home care under Medicaid. I feel that it would be useful to you if I begin when she first needed nursing care for the results of Alzheimer's disease, in 1980.

Mom had no pension though she worked eighteen years for N. J. Bell Telephone Co. and another twenty as manager of a small Florida "Mom and Pop" motel. Divorced at age sixty with no support payments, she lived on a small Social Security check and her only asset was the equity in her low-priced condo. In short, Mom had worked all her life but she was poor.

I decided in 1980 to place her in an intermediate care nursing home near my brothers in Georgia because Florida did not recognize Alzheimer's disease at that time as an adequate reason for receiving Medicaid nursing care, and I knew that we were dealing with a long-term illness. I had no way of knowing how long it would take for Mom to develop secondary problems that would be severe enough for Florida to approve her for Medicaid funding, plus I planned to move to Georgia in a year or so. Her assets of approximately $14,000 were assigned to me with the intention of using it to pay any of her expenses, through the years, that would not be covered by Medicaid, and she was accepted for Georgia Medicaid nursing home care. Georgia, at that time, paid the entire difference between the rate charged by the nursing home and Social Security benefits. Patients had their choice of any available bed in any nursing home that participated in the Medicaid program.

A combination of a dramatic drop in the quality of her care following the first Medicaid cuts and a severe infection that I feel certain was encouraged by her poor care made me decide to move Mom back down to Florida near me until I could move out of Florida myself. Mom was now unable to walk, talk, or feed herself, and she was incontinent with an indwelling catheter. Her doctor had advised me that from that point on, the length of Mom's life would depend entirely on the quality of her nursing care. I could not find a Medicaid bed for her in Florida. I could not even find a paying bed in a home that would later allow her to stay on Medicaid. That is the only way to get into a decent medicaid nursing home in Florida. You have to go in as a paying patient for a period of time up to several years or you will be put out when your money runs out. In other words, you have to have enough money to buy your way into a decent Medicaid bed. Florida pays a set rate for Medicaid nursing home care, a rate that is below the amount charged by every institution I know of. I took the only available bed, one in a nursing home that did not participate in the Medicaid program. I hoped to be out of Florida before her money ran out. Mom's care in that nursing home was good. About a year later, her money ran out along with an additional few thousand dollars of mine. Luckily, the home decided to try taking Medicaid patients for the first time. When Mom was accepted for Medicaid assistance, she was moved to another area of the nursing home, one where the care was of lower quality.

While in that section, the home changed administrators. The new man was a cold, unfriendly person, and Mom's care further slid downward. The home began having a severe problem keeping the patients supplied with clean clothing, while the laundry room was piled high with clothing that had not been distributed. I complained several times, to the staff and administrator. Unfortunately, I made the mistake of complaining one day in front of someone who, I later realized, must have been an inspector or someone else whom the nursing home did not want to know of the problem. The home changed policy and sent out notices that the patients would have to pay extra for laundry services. I never received notice nor did I ever get a bill. When I found Mom in bed with just an undershirt on and a sign on her closet not to do her laundry, I went to the administrator and asked him what was going on.

The man shouted at me to take my mother and get out, he was sick of ungrateful "dead beats" like us and he wanted us out! He raved at me, shaking his fists and pounding on the walls, about how no matter what he does for people like us, we don't appreciate it. I was terrified. It took me two days to get up the courage to report it to the Ombudsman. She could not promise immediate attention to the matter. She had a backlog of complaints. Upon the advice of a civil rights attorney, I reported the incident to Medicaid's investigative unit. They assured me that the administrator could not throw my mother out and went in the next day and began an investigation which lasted several weeks. They found ten violations in the nursing home. They notified the nursing home that it had thirty days to comply or lose Medicaid funding. The nursing home told them to keep their funding and notified all Medicaid patients that they had thirty days to leave or begin paying.

A social worker and I tried to find a bed for Mom but we could not. Mom's funds were gone, so I had no way of buying her way into a home anymore. One home in Tamarac, Florida, told me it would take her on Medicaid immediately, if I would make a contribution to the home that would be equal to the amount she would have paid as a paying patient for six months. To my knowledge only one Medicaid patient in Mom's nursing home was able to find a bed in the area. Our only other choice was to move her to a Medicaid bed in a nursing home in another area of Florida that had an opening. That meant Mom would have no one to look out for her, something I had found to be absolutely essential for someone like her who was totally helpless, both physically and mentally. We, fortunately, received a deposit on the sale of our home at that time. I immediately took a plane to Atlanta to see if I could find an open bed there. I found only one nursing home with an opening - actually, it had many open beds. I had been through many nursing homes by that time and this one looked average to me. It was certainly not the best I had seen, but then, neither was it the worst. I had little choice. We pushed up the closing date on our house and moved up to Atlanta. I heard from the Ombudsman just before we moved. She had gotten around to the investigation two months later, and, of course, found nothing wrong by that time.

Mom's care was pretty good when she first entered the nursing (12/83) home in Roswell, Georgia, a suburb of Atlanta. Within a few months, however, I began to notice that she was not always clean and the home began to look dirty. That summer was quite bad. I would find her in the same clothing she had been in during my previous visit days before. Her hair was dirty. She was left sitting in a mess for hours. The home acknowledged the problems and assured the families that it was taking moves to correct the situation of staff shortages. In the fall, the quality of her care began to improve some.

At the beginning of December, 1984, Mom was hit again with another severe infection and siezure, a situation similar to the one that occured in 1982 when she had been receiving poor care. This time her left hand began to contract and so did one of her eyes. The crisis passed but the infection did not leave, for reasons unknown. Her temperature spiked up and then would come down for a few days and spike up again late in the day for several days and so on. Even when her temp was down, it never was completely gone. This was an excellent excuse to leave Mom in bed and forget about her, which was precisely what happened. To make matters worse, problems began again in the spring, earlier in 1985 than 1984. I had to go in and demand care for Mom. She was left in bed all the time, regardless of her condition; she was not turned when she was left in bed, only once did I even see a turning chart; she was not bathed for months, her hair smelled and her clothing was always dirty. She developed bedsores. The room and furniture were always dirty, crusted with dried food. The staff became indifferent to Mom's needs and hostile toward me for insisting they care for her. Her bedding was usually dirty, left on for days at a time, often with the food encrusted side turned down and hidden. Needed medication was not ordered for her. There were never any washcloths for me to bathe her and seldom were there towels. I began taking Handy Wipes with me to use for wathcloths and I dried her with paper towels. I began washing down her furniture with paper towels each time I visited. And then the flies came. They were all over her, on her face, in her sores, on her food. Visiting her became a horror for me that left me either nauseated or in tears or both, so that I dreaded each visit and had to force myself to go back there each time. I tried to move her, but no nursing home would take her. I complained to the staff and supervision, but in view of what happened in Florida, I decided not to report the situation to the state. It took two to three people to move Mom

I could not chance my being kept out of the nursing home, because she desperately needed someone to speak up for her, and I could not risk her being put out or revenge being taken on her. She could not even cry out for help if she needed it.

There was no way out for Mom. Since the Medicaid cuts, Georgia nursing homes had adopted the same policy as those in Florida. The state of Georgia now paid a set fee for Medicaid nursing care, regardless of the rates set by the nursing home. Nursing homes no longer wanted Medicaid patients unless they could be guaranteed that the person would enter as a paying patient for a specified period of time before applying for Medicaid - anywhere from a year to several years. Some stopped taking Medicaid patients altogether. Just like the situation in Florida, the only nursing homes that readily accepted Medicaid patients were those that were so bad that they couldn't keep their beds filled with paying patients. However, the situation is a nightmare for all families needing a bed quickly, because the most readily available nursing home beds are usually ones in the worst nursing homes.

I was willing to pay for Mom to get decent care, but Alzheimer's is such a prolonged disease that I needed to know what kind of a burden I would be placing on my family. I had already spent several thousand dollars of our funds. I tried to get Mom's doctor to give me some idea of how long I might expect her to live at that point. He refused to discuss it. I asked my doctor and got a similar response. I decided to begin using the money I had set aside for her funeral expenses to hire a private nursing aide to attend to her needs. It was then, when I assisted her aide in undressing her for her first whirlpool bath, that I discovered that Mom's lower extremities were covered with open, running, infected ulcers. The one at the base of her spine was at least three inches across with the appearance of decaying flesh. The aide, her R.N. supervisor, and I were horrified. This, obviously, was the "unexplainable cause" of her persistent temperature. Mom's condition began improving immediately. In six weeks, her sores were healing nicely and her temperature had finally gone. The nursing home continued to be filthy and the staff aides now acted as if the responsibility for Mom's care belonged entirely to the aide I hired.

At the end of July, 1985, Mom developed pneumonia and died. It is difficult to say to what extent nursing home conditions contributed to her death. I had requested a "head only" autopsy of my mother's remains as ADRDA, the national Alzheimer's organization, recommends. That might have revealed the answer, but her doctor, one of the three doctors from the only practice I have ever known to attend patients at that nursing home, refused to cooperate with my wishes. I can say that the nursing home has since lost its Medicaid certification due to poor infection control and conditions that posed a threat to the health and safety of patients to the point where they posed a threat to life. In addition, three employees were arrested regarding incidents of violence against patients at this nursing home.

The owner of the nursing home appealed the loss of his certification. I was one of the witnesses for the state for that hearing. The investigation leading up to that hearing was unprecedented in the state of Georgia. It involved the attorney general's office and large numbers of professionals and family members. It was the first time the state of Georgia had gone after a nursing home owner in that manner. Nevertheless, family members and professionals wishing to have events at that nursing home made public never got to tell their story. The owner, a man reported to own seventeen nursing homes, struck a deal with the state whereby he would accept the charges if the state would limit his loss of certification to 120 days, something he claimed would cost him $450,000. The state agreed. It feels that having gone after such a rich, powerful, influential man as this man will do much to improve nursing home care in Georgia. Indeed, the number of complaints of nursing home abuse has multiplied. However, we who lived with the horrors of that place feel more is needed. This is the same man who in 1982 was sued by the state for Medicaid fraud for overcharging nursing home residents by $1,000,000. He settled with the state for dismissal of the suit for payment of $525,100. He is said to have bragged that they didn't find him guilty last time and they wouldn't this time either. In addition to the charges directly involving this nursing home, Medicare in Illinois is currently investigating several charges of possible fraud involving the medical supplier for this nursing home. I received notice of Medicare and Medicaid payment for medical supplies charges in excess of $1,600. I know from experience those supplies should not have amounted to any more than approximately $600.

Local media coverage of these events was minimal. The majority of coverage was by one television channel. Major newspaper coverage was, in my opinion, poor. It even ran a piece with family members who still had patients in that nursing home defending the owner and administrator, a meaningless exercise, since the owner, at meetings with the family members, had attacked those of us who chose to go public with our compliants and he had promised to pay the bill for family members who couldn't find another nursing home. Under the circumstances, they certainly weren't going to tell the press anything that would anger the man. One of the nursing home's employees who was to appear as a state witness was fired the day after the settlement. That's against the law, but the law provides for no penalty. Several of us who were state witnesses are pressing for further action and changes in policy. My piece (enclosed) on that subject was printed as a letter in the Atlanta Journal-Constitution. So much more needs to be done. We have reached a point in the greying of our country where we can no longer leave this to tomorrow. The next persons suffering such abuse may be us.

Sincerely,

Dorothy A. Doyle

Dorothy A. Doyle

enclosed copy of the record I kept of Mom's nursing home care during her final months.

Record of Patient Care & Conditions at a Georgia Nursing Home, 4/22/85-7/27/85. Regarding Angelina B. Palmieri, Resident

by Dorothy A. Doyle, Her Daughter

Mon, Apr. 22, 1985

Occasion: Call from charge nurse. Mom has chest congestion & possibly another UT infection. She called after noting that Mom had a temp of 103-104 F, onset Sat., but no one had called me since attempting to call me on Sat. and finding me not at home. Temp. today 101-102 F.

Findings: Mom had a mouth full of white mushy fungus. Her lips were covered with it and the skin wiped away when I tried to remove it. Mom appears to be very sick. She is unresponsive. She is dirty.

My Action: Asked charge nurse coming on duty to do something about Mom's mouth infection. She protested that she had just been in there and saw nothing. I insisted she come in and examine Mom's mouth. I cleaned Mom up the best I could and gave her water.

Nurs. Home Action: Charge nurse examined Mom's mouth and acknowledged that she had a yeast infection. She said she would call in an order for Mycostatin.

My Action: Made a decision to record in writing any visit that would help describe the conditions at this nursing home and the quality of care Mom receives there.

Findings - Summary of my recollection of conditions at this nursing home, Dec. 1984 to Apr. 22, 1985: Mom is dirty. She is usually found with food on her clothing, her face, and often the bedclothes. Her hair is seldom combed and it is impossible to recall at this time when I last saw it clean. I twice placed a bit of something in her hair when I combed it and tied it into a pony tail, to see if her hair was attended to. Both times I found the same bit still in her hair when I returned four days later and five days later. She is frequently found laying in feces. I sometimes cannot find anyone who can make time to clean her up so I clean up the mess myself. There have been times when I have been there at night and not seen any staff on the floor for 30-45 mins. Washing and powdering of her contracted hand is frequently neglected though it was determined in conference with her physician and the nursing staff shortly after her admission that this was to be a daily nursing task in order to prevent a breakdown of the tissue. It has become routine for me on every visit to bring Handi-Wipes with me to use for washcloths (none are normally available) and sponge her dirty face, neck, and hands ,give her water, and, frequently, change her dirty smock. I have found the same smock with the same foodstains on it still on Mom four and five days later, when I next visited. Though she is on an indwelling catheter and requires generous amounts of fluids, I frequently must go get drinking supplies in order to give her liquids. She seldom has a cup or straw or syringe handy. I bring a marking pen to note "KEEP" on any syringe I obtain from the nurse, so that it will not be thrown away and there will be a means available of giving Mom water should an aide should wish to. However, I strongly suspect that she gets no fluids other than those served with her meals. Most times I cannot find any cloth towels so I must use paper towels to dry her or a clean sheet, if the linen cart is in the hall and there are enough on it that they will not run short. Mom has developed skin ulcers. Since December, I rarely find her up and in her wheelchair. She is usually left in bed, even when her temp. is down. I make it a point to get her up myself whenever her condition permits.

Mom's room is dirty without exception. I have developed a routine of not only cleaning Mom but taking paper towels and washing the top of her nightstand and feeding table, and, often, the windowsill. I cannot recall ever finding them clean in recent months. They are always covered with dried food and liquids. The floor is always dirty. There are roaches in her closet and nightstand. Her sheets and pillowcases are often dirty. I have found the same foodstained pillowcase on her bed on my next visit four and five days later. Sometimes the side with the dried food is turned down and the clean side turned up. I change her dirty pillowcase whenever I can find clean ones on the cart, which is not often.

Tues., Apr. 23, 1985

Occasion: visit, illness

Findings. Mom more alert today. She looks tired and other than following me with her eyes, she is unresponsive. Temp. is 100 - 101F. Mouth is still full of white gunk. Hair now smells rancid.

My Action: Gave Mom sponge bath to extent I could. I requested someone clean the fungus out of her mouth.

Nurs. Home Action: Cleaned Mom's mouth. Took 3 pkts of swabs to clean it.

Wed., 4/24/85

Occasion: visit, illness

Findings. Mom much more alert, cough looser. Mouth appears to be pretty clean. Her contracted hand smells.

My Action: Sponged off Mom and changed some of her linen. Washed and powdered her hand. Mom's left hand is now contracting. I have tried to find washcloths to roll and place in it to keep it open but there are never any. Today I use several paper towels rolled together, as I regularly do.

Findings: Crumbs of dead skin coming off inside of hand seemed endless, indicating that hand has been negelected for a while.

Nurs. Home Action: none observed

Thur., 4/25/85

Occasion: Could not cope with visiting Mom again today. Though I feel she could use my assistance, I cannot bear to see her dirty and smelling again.

My Action: none

Fri., 4/26/85

Occasion: visit, illness

Findings: Mom's condition worse. Temp. 101 F. Her mouth is full of white fungus gunk again. She is experiencing discomfort when swallowing liquids. I suspect the infection may now be in her throat.

My Action: Performed routine tasks. Checked with charge nurse to be certain medication had been given for mouth condition.

Findings: Medication had never been ordered for mouth infection, though nurse had acknowledged her condition on Mon. and promised to call for medication.

My Action: I insisted a medication request be placed ASAP.

Nurs. Home Action: Obtained order for Mycostatin from doctor's assistant, who I am told is in nearly every day

Sun., 5/12/85

Occasion: visit, Mother's Day

Findings: Mom and room dirty, as usual. Room infested with flies and smells strongly of urine and feces. Soapdish has collected 1/4" of soap drippings now. Fluid intake/output chart is outdated. Incomplete entries of later dates are written in the margins.

My Action: Perform routine tasks of cleaning up Mom and her tables. Jeff tried to get rid of some of the flies.

Nurs. Home Action: none observed

5/13/85 -5/26/85

My Action: Visited various nursing homes again. Found one very good one, but it will not take Mom with open sores. Put Mom on several waiting lists. I strongly suspect that her Medicaid status is unwanted

Mon., 5/27/85

Occasion: routine visit

Findings: Mom is filthy. Could find no towels nor sheets nor any other linens to use to wash and dry her. Her forehead is creased and her eyes tensed; she appears to be in pain, yet I cannot find anything other than a few sores when I check her. My relationship with the staff has become cold and tense because everytime I come in, I politely but persistently ask them to attend to her. Another patient's daughter was sounding off about the nursing home in the upstairs hall as I was leaving.
to

My Action: Decided to begin using money I saved for Mom's funeral expenses to hire a private aid since I cannot find an opening in another nursing home and I see no evidence of the conditions and care of Mom improving.

Wed., 5/29/85

Occasion: Notify nursing staff that I had hired a private aide from Health Care to come in three times a week.

Findings: Met with Dir. of Nursing. She told me she was 40 aides short a few weeks ago and 26 short the beginning of this week and 20 short now. She tried to tell me this is a seasonal problem, however, I have seen it this way for a year except for the few months before Christmas '84.

Nurs. Home Action. Dir. promised to work with the aide and promised to set up a plan for improving Mom's care. Was told she would be right down to see the charge nurse. I waited until after 3 p.m. but she never came down. I explained my plans to the charge nurse myself. She apologized to me for the situation.

Thur., 5/30/85

Occasion: Meet with representatives of Health Care Services to set up a program for Mom's care.

Findings: Hannah, the aide, and I prepared Mom for her first whirlpool bath. I soon discovered why Mom has appeared to be in pain. We found Mom's legs, feet, hips, and thighs covered with puss-ridden, running, 1" - 2" sores up to 1/2" deep. The sore at the bottom of her spine is at least 3" across and the flesh is so broken down that it smells like decay. John ____, RN, Kelly supervisor indicated that it was evident Mom had been "neglected for quite a while."

My Action: Discussed Mom's problems and needs with John ____ and Hannah ____ and set up a program for her care by Hannah three times per week to include:

*Whirlpool bath and wash hair
*wash, dry, powder hand
*feed midday meal
*give fluids
*change Mom's clothing
*change bedclothes
*get Mom up and into her wheelchair unless she has more than a low-grade temperature

Nurs. Home Action. Staff promised to assist Hannah in any way. "Just ask."

Sun., 6/2/85

Occasion: routine visit

Findings: Mom was in bed Her temp 99.4 F Mom laying in feces
Aides on floor very busy

My Action. Requested from Charge Nurse the Nursing Home's policy regarding getting Mom out of bed Told there was none Sponge bathed Mom and cleaned up the mess she was laying in. Got her up into her wheelchair. I requested it be put on record that I wanted Mom out of bed for at least a short time on every day when she had no elevated temperature.

Thur., 6/6/85

Occasion Letter arrived from Nursing Home Administrator stating that people who were unhappy with loved ones care at Nursing Home were probably just upset because they were suffering from "guilt." Administrator suggested anyone unhappy with the nursing home should remove their loved one To me, the letter confirmed my belief that callousness and lack of compassion for the sick and suffering at this Nursing Home is a matter of policy

Sun., 6/9/85

Occasion routine visit by Bill & me

Findings Mid-afternoon, Mom was still not cleaned up for the day and was still in bed.

My Action Request that staff attend to Mom's needs

Nurs Home Action Cleaned Mom up for the day

Sat., 6/15/85

Occasion: routine visit by Bill, Jeff, me

Findings: Fly infestation very bad today Jeff, who has not seen her in a while, remarked that you could tell she had an aide coming in because she appeared to be in the best condition of anyone he saw. The room is still filthy and the soap builds on.

Mom's condition and appearance have improved dramatically in the two weeks since her care by the private aide began Her hair is always clean and her clothes and bedclothes are at the worst two days old now. Her sores are healing nicely. She is more alert

My Action Room cleaning routine.

Sun., 6/23/85

Occasion: routine visit, Bill & me

Findings: 2:30 - 3:00 p.m. Mom unchanged from night before. Though it is hot outside and the temp. is expected to be in the 90's today. Mom is dressed in a long-sleeved, flannel nightgown with a closed front, covers pulled up over her arms. Air conditioner is off, window open. Mom is sweating profusely and the skin on inside of her hands is white and puckered as when hands are left in water too long. Her water pitcher is empty and literally covered with dried, pureed food. Intake/Output chart expired on 6/20/85. There is no hot water to bathe her, the second time I have found that recently. She has dried food on her face and hands and mouth.

My Action: Cleaned her up, removed flannel gown, and put on a cotton smock. Only washed her hands due to cold water. Bill asked for a new pitcher at the nurses' station and was told they would get one later. He asked where he could get one for them. He obtained a pitcher from upstairs but there was no ice nor lids. We gave her water. I removed the outdated fluids chart and took it to the charge nurse.

Findings: Mom was frantic to get the water. She couldn't get enough. Bill was afraid to give her more than 1/2 of a pitcher. (Mom always hated water.)

Nurs. Home Action: The five people at the nurses' station, including, I believe, two nurses, were arguing about who should have bathed Angie today.
A new Intake/Output chart was put up.

Tue., 6/25/85

Occasion: 1:30 - 2:00 p.m., visit to check on assistance given to aide

Findings: Found Hannah very upset. Sat. she found Mom dressed in a long-sleeved flannel nightgown with the covers pulled up the windows open, the A/C off, though Sat. was a hot day. She said Mom's color was so poor that she was afraid for her. She complained that she gets little cooperation from the staff, and now that they know when she is coming in, they do nothing at all for Mom on those days and have even left her in feces and tried to make it appear that she just had the BM. She could not bathe Mom Sat. either because there was no hot water. She said the staff is often acting spiteful because of her complaints against their poor care of Mom and the condition she finds her in. They are not cooperative and will not break up a conversation to help her lift Mom. She had asked the charge nurse 30-45 min. before I arrived to dress Mom's sores because she had to leave soon to catch her bus, but the nurse had not yet come in. Hannah threatened to quit caring for Mom because she was tired of them never having necessary supplies and tired of finding Mom and the place such a mess. She, too, has been washing the furniture with paper towels.

The flies are awful today. They are walking all over Mom, in her sores, over her food.

My Action: Went to find the nurse to dress Mom's sores.

Nurs. Home Action: Upon seeing me coming, the charge nurse jumped up and called out, "Oh, I was just coming in to take care of Angie."

My Action: I drove Hannah to the bus stop to try to avoid having her miss her bus.

6/25/85

Occasion: 8:00 - 9:00 p.m., Lisa (my dtr) visited Mom

Findings: Mom laying in feces. No staff seen nor heard on the hall throughout her entire visit.

Her Action: She got the Chux herself and cleaned up the mess and Mom. (She has done this on several visits when either finding no staff on the floor or finding the staff so burdened that making time to care for Mom would be difficult.)

Wed., 6/26/85

Occasion: Tried once again to find another nursing home for Mom.

Results: No openings. The good ones have waiting lists for Medicaid beds, one has a two-year list.

My Action: Put her name on more waiting lists.

Prospect: Poor chance of moving her, if any at all.

Thur., 6/27/85

Occasion: Telephoning nursing homes.

Results: No luck. But official at Home "A" took the time to speak to me about Mom's sores. She said a culture on them is necessary to determine the type of infection. She said it was her experience that the sores alone could be causing Mom's persistent low-grade temp. and they could be difficult to heal without knowing what specific direction to take with medication.

Occasion: Telephone call from the office Manager, Health Care, before 5 p.m. requesting permission to pay Hannah without a signed time slip. Nursing Home staff refuses to sign hers any longer. They claim she is cheating me on the time she spends. Because Hannah has two hours of bus travel and a long wait between buses, I have told her that she may adjust her hours to any hours that cover the midday meal and I have no objection to her even leaving early to catch a bus, provided she has completed her tasks for the day.

My Action: I agreed to accept time slips unsigned.

Fri., 6/28/85

Occasion: Routine visit

My Action: Decided to go talk to Nursing Home Administrator about the poor care Mom receives and the lack of staff cooperation with the aide I hired.

Findings: Administrator was out. This time I believe it is so because the door to her office is locked and there is no light coming from inside. Have tried to go in to talk to her before and found her door locked and the light on. No one answers my knock. It is said that she locks her door when she is in so that family members cannot come in her office. At approx. 2:30 p.m., two aides were just cleaning Mom up for the day. That process consisted of removing her smock, wiping the food off her face with it, brushing the crumbs of food off her neck and chest with it--period. The intake/output chart had run out yesterday. It had intake entries on one shift only on the 25th and 27th and output entries on two days during one shift of 50cc. The young nurse who told me a few weeks ago that Mom didn't need any attention to the three major infections on her foot, that it was inflamed and swollen because I insisted on getting her up out of bed, came in unwrapping a Tylenol suppository. She reported that Mom had a temp. of 102 F today and 101 F yesterday, but Mom had not been seen by the Dr's assistant nor had anyone called the Dr. to report her condition, nor had anyone notified me.

My Action: I expressed concern that Mom would be going into the weekend with an infection starting.

Nurs. Home Action: The nurse shrugged and refused to discuss it.

My Action: I requested that she change the bandages on Mom's legs because they were badly stained with new and old, dried drainage.

Nurs. Home Action: I was told she didn't have time. She had a medication order to call in and an admittance.

My Action: I insisted she either change them herself or leave a note for the next shift to do it. I persistently tried to get an answer as to whether or not the doctor had ever had a culture done on Mom's sores.

Nurs. Home Action: Nurse finally agreed to leave a note for next shift regarding bandages. After much evasion, she said that no culture had ever been ordered, and if the doctor had thought Mom needed one, he'd have ordered one. She informed me that the Nursing Home would not sign anymore time slips for Hannah--a new Nursing Home policy, she claimed.

My Action: I went to Dir. of Nurses and strongly complained that no one seemed to have any time for my mother, no time to bathe her, no time to order medication for her. Her needs seemed to come last in their line of priorities.

Nurs. Home Action: Dir. told me she would immediately call the doctor for medication and speak to him about a culture. She tried to tell me the aide was cheating me and didn't want to do her job.

My Action: I told her that has not been my experience. I hired the aide so that Mom could have additional care. I did not hire her to do what Nursing Home should be doing. I asked when her staffing problems would be solved.

Nurs. Home Action: Dir. said Nursing Home is fully staffed now. But when I told her that I was glad because now I could stop the private aide service, she advised me not to do that, to wait a while longer. She advised me that the nurse who was so rude to me and uncooperative was leaving their employ in two days. She said she would talk to the nursing staff to try to improve Mom's care.

My Action: Spoke later by phone with Dir. of Nursing, she had requested medication for Mom and spoken to the Dr. about the culture, but she was evasive when I tried to determine just what the Dr. had said about having a culture done. I was unable to get a satisfactory answer.

Sat., 6/29/85

Occasion: Hannah called in sick. is trying to find someone who will come in tomorrow.

Sun., 6/30/85

Occasion: Called three times trying to check on Mom's condition but kept getting cut off when they tried to transfer the call.

Tue., 7/2/85

Occasion: Routine visit

Findings: Hannah was with Mom but could not bathe her because Mom was ill. She had diarrhea, probably from the antibiotics, the nurse said. Mom's condition appeared somewhat improved, but there were flies all over her. Someone splashed brown liquid all over the wall to a height of about eight feet, then left it to dry. The elevator smells like decaying matter.

Thur., 7/4/85

Occasion: Routine visit

Findings: Mom still has diarrhea. She was up and somewhat cleaned up, hair combed, hand was unattended. She has a fungus infection in her mouth again.

My Action: Brought in some kefir for Mom to drink. It is often used for children who experience diarrhea when taking antibiotics, I am told. Bill asked the nurse to please order something for Mom's mouth infection.

Nurs. Home Action: Nurse noted to request medication for mouth infection, something is already being administered for diarrhea.

Wed., 7/10/85

Occasion: Routine visit

Findings: Mom looks unkempt and has food all over her. She is still holding scrambled eggs in her mouth from an earlier meal. No staff visible on floor.

My Action: Cleaned Mom up the best I could but left the furniture and windowsill dirty.

Nurs. Home Action: none observed

Sat., 7/13/85

Occasion routine visit

Findings: Nurse who was supposed to have been leaving in two days last month, according to the Dir. of Nurses, was charge nurse. The room was exceptionally dirty. The fly infestation terrible. Mom was in a mess from diarrhea. An aide complained that Mom's Kelly aide had not been in all week and they "had to do everything" for Mom. The Kelly Health Care aide is no longer showing up regularly.

Nurs. Home Action. Cleaning person came in to clean the room, left tables dirty.

My Action Routine cleaning of Mom and room. Bill put garbage from tables on floor she was about to do so that it would be sweeped up. Bill and I purchased fly paper and hung some in the room.

Nurs Home Action: The cleaning person returned and mopped around the garbage, leaving it on the floor, and she wiped away the weeks old spider webs on the windowsill.

Mon., 7/15/85

Occasion Phone call and routine visit

Findings. Charge nurse said private aide did not show up for last assignment. She raved so profusely about how well the aide cared for Mom that it became obvious that she was trying to convince me not to be angry with the aide service and continue to have the private aide care for Mom. She stated that she would not have time to change Mom's bandages without the aide preparing her first. She said the complete process of removing the old bandages and cleaning the wounds took approximately 45 minutes and she did not have that much time to spend on one patient.

My Action I agreed to continue the aide service.

Wed., 7/17/85

Occasion: routine visit

Findings: Mom was being returned to bed by a new aide. Mom was in some pain as I have frequently noticed after her sores are medicated and bandaged. The aide had been told not to wash Mom's hair because there was no shampoo, though a large bottle of shampoo is on Mom's nightstand. The room is dirty. The aide complained that no ice was available; I have not seen any ice in the pitchers in months. The nurse reported that Mom's temp. has finally gone completely. Her sores are healing nicely.

My Action: Asked aide to request Tylenol any time she sees Mom in discomfort after her sores are treated. Requested Tylenol from the charge nurse. I pointed out to the aide and nurse that the large bottle of shampoo that I had provided for Mom had been there all the while. I requested cooperation with the new aide from the Nursing Home staff.

Nurs. Home Action: The nurse repeatedly tried to change the subject and refused to discuss cooperating when I persisted. She administered Tylenol.

Sat., 7/20/85

Occasion: routine visit

Findings: New aide today. Mom was just being removed from Whirlpool. She looked very well and was alert, pleased to see me, smiled. The room was a mess.

Wed., 7/24/85

Occasion: 10 p.m. Received call from chg. nurse Mom is very sick, having difficulty breathing, may not live through the night.

My Action: Left immediately for Nursing Home.

Findings: Mom has no temp. but has heavy chest congestion. Pulse difficult to find, then very rapid and irregular. She is struggling very hard to breathe and moaning with her labor between breaths. She is completely unresponsive and on oxygen. She appeared clean and so did her bed. She refuses all liquids and food.

My Action: Try to make her comfortable.

Nurs. Home Action: Appropriate only.

Thur., 7/25/85

Occasion: visit, illness

Findings: Mom looks the same to me. Her breathing is just as labored, but her pulse is somewhat stronger and more regular. Mom looks clean and so does her bedding.

My Action: Same as yesterday.

Nurs. Home Action: Charge nurse an agency nurse, not staff, was extremely caring and sympathetic.

Fri., 7/26/85

Occasion: visit, illness

Findings: Mom doing very poorly. She looks grayish, eyes red and swollen. Seems to be struggling harder to breathe. She is very lifeless. There are flies walking all over her face and eyes and mouth. It is horrible. Her lips are dry. She still is taking nothing, food nor liquid. Her pulse unstable.

My Action: Talk to doctor, notify family, speak to funeral home. Try unsuccessfully to find the other rolls of fly paper. Remove a smock from the closet and swing it around to keep the flies off her. Otherwise same as before. Later found fly paper and hung some above the bed.

Nurs. Home Action: Nurse from agency very helpful and comforting. She gave Mom some Demerol to make her more comfortable and stabilize her pulse.

Sat., 7/27/85

Occasion: visit, illness

Findings: Mom's left hand blue and her breathing very shallow. Eyes beginning to roll. She is clean and bed is clean.

My Action: Same as before

Nurs. Home Action: Nurses and aides attentive, sympathetic, and helpful.

At approximately 9:45 a.m., Mom stopped breathing.

Chairman HEINZ. Ms. Doyle, thank you for your testimony. You are a very courageous woman to have testified, to have gone through as best you could what was a truly trying experience, going back over a number of years. And I think every member of this committee can truly identify with you and feels just wrenched apart by what you went through.

And I suppose the saddest part is that you are not the only person who is going through that. You obviously came into contact with a very substandard nursing home, one that was chronically so. And if you just multiply that by all the number of people in that nursing home, and then multiply that by 600 or 900, which is what our investigations show is the minimum number of chronically, grossly substandard nursing homes, and then just imagine that number of people like you who are going through what you have gone through, I think people begin to get a sense of the widespread nature of this problem.

Ms. Dowling.

STATEMENT OF PEGGY DOWLING, NAPA, CA

Ms. DOWLING. My grandmother was brought into an acute hospital after having a stroke in March 1985. She was there approximately 3 weeks when they told us they could do nothing more for her and that we would have to move her into a convalescent hospital.

At that time, they said that if we did not find a place ourselves, that she would be moved into the first available bed in any hospital, convalescent hospital, in the State of California. We elected to bring her to Napa, where the family was, and we would be able to take care of her.

In looking for a convalescent hospital in Napa, we found out immediately that it was going to be very difficult. She had 60 days of Medicare to go before she would become Medicaid. That limited us to only three places, and only one of those we thought would be what we were looking for.

Soon after we transferred her to the hospital in Napa, we found her care to be very lacking. We would come in and find her not strapped into a wheelchair. Her left side was paralyzed, and her button for calling the nurse would be tied under the bed or underneath her left side, where she could not reach it.

The feeding of her by the aides, they would have one aide to about nine feeders, and they would shovel it in so fast that after two bites, she would quit eating. So we took it over ourselves, my mom and my sister and I; they did lunch; I did dinner after I got off work. And then we went in at least two other times during the day.

On the night of July 12, Gram showed a change in her health. She began having stomach cramps and vomiting and would not eat. My mother voiced to the nurse that she thought the doctor should be called. On July 13, she was much worse. They assured us that they would do that. They would have to take her vital signs first, and then they would call the doctor.

On Sunday morning, July 14, my mother went in to see her, and she was almost comatose. She was in extremely bad pain. My mom came home very upset, and said they had not called the doctor, and it did not look like they were going to call the doctor. So I did it myself. He ordered an ambulance at 12:55 p.m. She died within hours.

We were afraid to complain about her care during the time because we were told that if we did, she would be moved to the back room or the back section of the hospital, which was the worst.

At the hospital before she died, her doctor told us that we had reason to complain, that her condition should not have been that way, and to please complain about it.

We contacted the ombudsman, who told me about their program. I had not known about it before. If I had, I would have been in there months before this happened.

And then we went into the Ombudsman Program in Napa. They contacted the State Office of Facilities Licensing and Certification, where we filed the complaint. They came in. They did an investigation and closed it within 10 days—or, excuse me, in the appropriate time that they had, and I asked how long that was and was quoted 10 days to do the investigation.

I was really disappointed and upset when only a "B" violation was given, and the nursing home was fined $1,000, and they closed the case. I did not accept it. I contacted the Ombudsman Program again. They contacted the State Justice Department and somehow got the case reopened. Further investigation indicated to the State that my grandmother's death would not have occurred had the nurse called the doctor when they should have, and the violation was then raised to a "AA" citation, which was a fine of $25,000.

Until I was contacted by the Ombudsman Program in January of this year, I had not heard anything more from the State on their actions, what was being done with my case. In January, they asked me to write a statement to the State Little Hoover Commission in Sacramento, CA, which I did. Approximately 3 weeks later, I got a letter from the State Office of Facilities Licensing and Certification, assuring me that they would keep me informed of all investigations or anything further that went on with my case. They have not done that. I have not heard anything more at all, until I was contacted to come back here and voice what happened.

[The statement of Ms. Dowling follows:]

Testimony of

PEGGY DOWLING

before the

U.S. SENATE SPECIAL COMMITTEE ON AGING

May 21, 1986

My grandmother was brought to an acute hospital when she had her stroke. She was there for several weeks when we found out she had to be moved to a convalescent home because the hospital could not do anything more for her. The hospital told us that she would be moved to the first available bed in any nursing home in the state of California. We asked if we could bring her to Napa where the family lived. They said it would be okay if we could find a place.

In looking for a convalescent hospital in Napa, we immediately found out that we were very limited in available facilities because Gram was a Medicare patient. She had approximately 60 days of Medicare left and then she was going to be put on Medicaid.

Soon after we got Gram transferred to the convalescent hospital in Napa, we found out that her care was not what we thought it should be. My mother, sister and I worked out a routine that would allow them to feed her lunch and I would feed her dinner after I got off work. We also stopped in the early morning and afternoon to visit with her. Often we would find her restraining strap holding her up with her paralyzed arm hanging over the side of the chair onto the floor. Sometimes her call button was put on her paralyzed side or tied underneath her bed. When my mother voiced her concern to the aides, they told her not to complain because Gram would be transferred to the back section and it was the worst. Because we were afraid to complain, we took on more and more care of Gram ourselves.

On the night of July 12, 1985, Gram showed a change in her health. She started to have stomach cramps and didn't want to eat. On July 13th, her condition worsened. My mother asked the nurse to call the doctor. The nurse told her that she could not call the doctor until Gram's vital signs were checked. She assured us that this would be done on each shift and the doctor would be called when it appeared necessary. On Sunday, July 14th, my mother went in to visit Gram. She came home upset. She said Gram was in extreme pain and that they had not called the doctor and it looked like they weren't going to. I called the doctor immediately myself and he had an ambulance sent to bring her into emergency. This happened around 12:55 p.m. Within two hours, Gram died.

After Gram's doctor saw her in the emergency room, he suggested we had reason to complain to the Ombudsman program about Gram's care in the rest home. My mother and I went into the Napa office two days after Gram died. They contacted the state Office of Facilities Licensing and Certification who did an investigation into her death. I was really disappointed and upset when I found out the state had issued only a "B" citation to the rest home and the case had been closed. The inspector for the State of California told me that in the time allowed for investigations, her findings did not warrant a "AA" citation. I asked how much time was allowed and was told 10 days. Again, I spoke to my contact in the Ombudsman office who contacted the State Justice Department. I feel strongly that because of their involvement, questions were raised about the "B" citation. The result was that the case was reopened and more evidence was found. The "B" citation was raised to a "AA" citation, and the fine was increased from $1,000 to $25,000.

Until I was contacted by the Ombudsman in January, 1986, I hadn't heard anything more about the State's actions since the previous August. When I was contacted, I was asked to present a statement to the State Little Hoover Commission, an investigative panel, about Gram's death. Approximately three weeks after submitting my statement, I received a letter from the State Licensing and Certification Office assuring me that I would be kept up-to-date on Gram's case. I haven't heard anything more from the state since then.

OMBUDSMAN PROGRAM
VOLUNTEER CENTER OF NAPA COUNTY, Inc.
1700 2ND ST., SUITE 308
NAPA, CALIFORNIA 94559 (707) 252-6222

July 16, 1985

TO : Licensing & Certification
FROM: Kristin Casey, Napa County Ombudsman Program
RE : Complaint against Convalescent

My office was contacted by phone yesterday at 400 PM, by Betty , daughter of Anna . Anna had been a patient at from March 22 to July 14, when she passed away. Mrs. and her daughter feel that was negligent in the care her mother received the last two days of her life, and that Mrs. suffered needlessly and perhaps died unnecessarily, due to lack of adequate nursing care and judgment.

Mrs. statement follows:

Saturday, July 13, 1985--NOON

We got there around noon to give ma her lunch and she said that she had thrown up that morning and didn't want to eat anytning. The nurse came in with her pills and I told the nurse that ma's stomach hurt and she didn't want to eat. The nurse gave her her pills and the Milantin.

I told the nurse that ma felt cold and clammy, which is how she feels when she hurts. The nurse felt her forehead and said that it was just because her hair was wet from washing. She didn't take her temperature or anything, but she said ma's vitals were normal that morning and that they would take her vitals every shift change.

I also told the nurse that 10 years ago my ma had had heart failure and when the dr. released her from the hospital he said that if she ever got sick to her stomach don't ignore it and never assume that it was a bug, that he wanted to know immediately if something like that happened. So I let her know that the throwing up was not normal with my mother, and that her old doctor had said it was too important to ignore. The nurse didn't say anything about that, but just said the Milantin might help, and then she left the room.

continued (p. 2)

Saturday, July 13--5:15 PM

We went back to give ma her dinner, and she didn't want to eat anything still. When the nurse came in with her pills that night, I told her ma couldn't eat because of cramps in her stomach. The nurse said that ma was having sherbet for dinner, and maybe that would be good for her. I asked the nurse if she couldn't give ma something for the cramps. The nurse gave ma her pain pill, her other pills, and said maybe the Milantin would help.

My mother said that she was in awful pain and she didn't know why she had to hurt like this. I told her I didn't know why either. Ma said that if she ate she would throw up, and I again told the nurse that that was very unusual for ma. The nurse didn't answer that. The nurse was busy keeping track of a wandering patient, so she couldn't stay long in our room. It didn't seem like this nurse knew anything about what I had said about ma's problems to the day nurse--my concerns didn't seem like they were important, and I was beginning to feel as if I was being overprotective, because no one was responding to my worries.

The nurse did say she would keep her eye on ma, and that she would be there until 11:30. *I assumed that the nurses would know to call ma's doctor * she was taking a turn for the worse or if she needed a doctor.

Sunday, July 14, 1985--before 9:00 AM

* see addendum

We continued to be worried about ma, so my daughter, Peggy, decided to call   to see how she was. The nurse told Peggy that ma was fine and that she was better this morning. The nurse said that she ate her breakfast but threw it up. When Peggy got off the phone she was angry and said to me, "The damn fools--how can she be better if she's throwing up?" So I decided to go in and see ma for myself, before I had to go to San Rafael.

Sunday, July 14--9:15 AM

We went to   and went into ma's room. She was laying there kind of limp and her face looked all sunk in and she had trouble talking--her speech was noticeably slurred. My other daughter, Donna, said to ma that she sounded like she needed a drink and she gave her a sip of water, which seemed like it helped her a little. Her aide was very nice and was brushing her hair when we got there. The aide said "I'm so worried about your mother"--she said she was worried both yesterday and today.

cont. (p. 3)

I went out to the desk then to talk to the nurse, an LVN. I told her that I thought my mother was quite sick and I again pointed out that she was cold and clammy. I said she still was having stomach pains and cramps, and I said I thought they ought to call the doctor. The nurse said she couldn't call the doctor until ma's vitals were taken. And I said "haven't they been taken?' She said they hadn't been taken since Saturday morning. I said they told me they would take the vitals every shift change, but apparently they hadn't. And that was it. She just stood there staring at me. She wouldn't call the doctor until they took the vitals.

I went back into ma's room and she said again, "I don't see why I have to hurt like this. We talked to her awhile, and I told her my other daughter, Peggy, would be in to see her after we had to leave.

We went home and I asked Peggy to go in and take her husband with her, becuase I felt something was very wrong. Peggy decided not to take any more time to go in, and she called Dr. immediately. Dr. called Peggy back around 11:00 AM. Peggy told him that she was frustrated because would not call him and the family felt he should have been called on Saturday. Peggy told the dr. that we were afraid ma had had another stroke and he asked what made us think that. We told him because her face was sunk in and her speech was slurred and she was cold and clammy and had been throwing up. He had ma sent to emergency at so that he could examine her.

Sunday, July 14--11:45 AM

Peggy's account, at QVH: I got to the about quarter to twelve. Anna had not been brought in, so I called the facility around 12.40 to see if she was on her way yet. A girl named Terry answered the phone, and I said "hi Terry, has the ambulance come to pick up Anna yet?" She asked, "Who is this?" I said "Anna 's granddaughter, Peggy She said, "No, we're waiting", and she hung up. The way she hung up, I felt that they knew they had done something wrong.

When the ambulance brougnt gram in, I said "Gram, this is Peggy" but she didn't answer me, she just lay there--she wasn't coherent, her eyes were moving back andforth and she was breathing really heavy. My husband,David, came over and I yelled louder at her that it was Peggy and David. She still could not answer, and I started to cry. I asked David why they would let her get in this shape without calling the doctor for help. David told me to get myself under control, so I walked away. I went back over to her after a moment and I again yelled "Grandma" at her. This time she just made a sound like "uhh".

cont. (p. 4)

(Peggy's account at QVH):

At that point they took gram in, and I called my mom to come up from San Rafael because of how bad gram was. On my way to the phone, the medics from Ambulance Service stopped me and asked if I was Anna 's granddaughter and I said yes. The medic said "I know you're upset but I feel you should know that when we got there to pick her up, the nurse wasn't very cooperative." He said that he had to verbally and using his fingers get her to tell him anything. He asked the nurse what was wrong with gram, and she replied "She's always like this". I said she was not always like this, that she's usually alert and her mind is quite good, even though she's 92. Then he said he asked the nurse what gram was being treated for at , and he went through a list of things: Heart trouble, stroke, diabetes. The nurse answered yes on the diabetes and he asked her if gram was given insulin. The nurse said yes, she was given her insulin on both Saturday and Sunday. The medic thought gram might be suffering from a diabetic coma, from what he could get out of the nurse at . He asked what she had eaten. He told me it was like pulling teeth to get any information from about gram's condition. He was very upset, and seemed to know that I had called the doctor, that the facility had not.

Pt. not on insulin!

When I went back in, they let us go in to be with gram. I could feel that the doctor was concerned about the condition that she'd been brought in. Gram was more alert now, but she couldn't talk. We were told that she was dehydrated.

Around 3:00, the doctor took the family into the conference room and he explained that he felt that this was something fatal, that she had a blockage of some kind. Donna asked Dr. if had called him, and he said he had received no other phone calls regarding our grandmother besides the call from me. He said he felt things had not been handled as they should and we had reason to raise a complaint, and that we should talk to the administrator and also call the Ombudsman Program. He also questioned us about the insulin, because the nurse had said she took insulin and he knew she was not on insulin at all. Dr. said he was going to admit gram into the hospital.

Gram died within about an hour of our talk with Dr. . We feel that all this suffering that she went through was not necessary, if the facility had been more attentive to her change in condition and if they had listened to the family instead of ignoring us.

Monday, July 15, 1985--11:15 AM

Peggy's account of meeting with Administrator and Director of Nurses: We went into Betty s office because I told her I wanted to talk to her about the handling of my grandmother, Anna . She said "She was transferred." Then I said "She died last night." The administrator just

cont. (p. 5)

looked at me and said nothing. I asked her to tell me the proper procedure that the nurses were to use when the family requested that a doctor be called. She did not answer me. She picked up her loudspeaker and sternly requested that Lynn to come to the administrator's office. She announced that twice. I then asked her why the nurse would tell the medics that my grandmother was given insulin when she wasn't on it. At that point she got up and said "I'll go and get the records." She came back in with the chart and opened it up and said there wasn't anything about insulin in it. She said didn't understand why they would have given her the Milantin when she had stomach cramps and was throwing up. I told her I felt that the last 3 days of care for my grandmother was the pits. She then again picked up the loudspeaker and called for Lynn to come to her office. I asked her why they would feed her oatmeal and eggs for breakfast when she was throwing up. She said "I don't know".

When Lynn came in she said to my mother, "I'm so sorry about your mother"--it sounded phony. Betty turned to her and said that we were there becasue we were unhappy about the circumstances surrounding gram's last 3 days of care. Lynn turned to mymother at stated that my grandmother was always having pains and mymother responded that all she had to do was look at gram to tell that something was wrong, and she does not even have medical training. Lynn then gave the excuse that the nurse had "just been hired." I said I hoped she had been able to speak and read English in order to be in this position; I also said I saw that they have a high employee turnover at . They acted like I hadn't said anything. Lynn again stated that the nurse was new. I again brought up the question of why the nurse should tell the medic that my grandmother was given insulin when it wasn't true. Betty said, "If the nurse said that." I responded with "The medic had a clipboard with his questionnaire and the nurse's answers, which he gave to Dr. ". And Lynn said yes, that she had spoken with Dr. that morning. I again asked why gram was given oatmeal and eggs after having thrown up all day Saturday. Betty said she only threw up after she ate, so it was only three times. My stated, "She only eats three meals a day, and she threw all of them up." I said anyone should know that if she was throwing up all her food, she should be given liquids. Then I asked for the name of the nurse; Lynn hesitated and looked at Betty and asked her if she should give me the name and Betty replied yes. She gave me the name of . They could not give me her employment date. Lynn also made a point of saying she was the "weekend nurse" and again added that she's new. I said I was not going to accept the excuse that the nurse was new; we also feel that there is no excuse to have less than competent nurses scheduled on weekends.

cont. (p. 6)

LYnn stated that she would be working with Dr. on the investigation. I said I wanted a copy of everything in writing that came from the investigation, and I wanted to be updated on it at all times. As we left, I asked the administrator if she is the last one to know what happens around this place, because this was the first she'd heard of all this. She replied, "Apparently". Lynn replied "Only on weekends." At this point it was noon on Monday, and I said to Betty, "That's too bad."

I just want to add that gram always held on to the idea of living to be 100. Hardly any day went by that she didn't mention the cake that Mike was going to make for her on her 100th birthday. She always said she would hold him to it.

* Addendum concerning Peggy's call to on Sunday, July 14:

When I called that Sunday morning, I told the girl who answered who I was and said I wanted to know how my grandmother was. The receptionist went and got a nurse for me. It was hard to understand the nurse, because she was oriental. The nurse said gram threw up all day Saturday, seemed to be better Saturday night, but this AM was throwing up again after they fed her breakfast. And then she hung up.

* Addendum from Mrs. concerning Sunday AM:
The cook from the kitchen came be and asked how my mother was, and I told her she was ill and throwing up and she couldn't eat the food. She said she didn't know that, and if they had told her, she would have sent her liquids to eat.

SECTION 1424 NOTICE SUPPLEMENT

-03

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	72311(3)(B) - continued		
	6-23 1000 am ..."changed foley, no out put on		
	noc..."		
	6-23 ..."very poor I & O general condition		
	poor"		
	6-30 ...."Foley patient but with only 75 cc		
	output the whole shift".		
	On July 1 the patient was transferred to acute care.		
	FAILURE TO NOTIFY THE ATTENDING PHYSICIAN PROMPTLY OF		
	ANY SUDDEN AND/OR MARKED ADVERSE CHANGE IN SIGNS,		
	SYMPTOMS OR BEHAVIOUR EXHIBITED BY A PATIENT HAS A		
	DIRECT OR IMMEDIATE RELATIONSHIP TO THE HEALTH,		
	SAFETY OR SECURITY OF THESE PATIENTS AND ALL THE		
	PATIENTS IN THE FACILITY.		
01H-233-032	CLASS "B" VIOLATION		
72311(3)(B)	Nursing Service - General	$1,000.00	0900
	Nursing service shall include, but not be limited		7-30-85
	to, the following: Notifying the attending physician		
	promptly of: any sudden and/or marked adverse		
	changes in signs, symptoms or behaviour exhibited		
	by a patient:		
	Patient "B" is a 92 year old female admitted to the		
	facility 3-22-85 with diagnosis of s/p C.V.A. -		
	diabetes - L hemiparesis. The medical record docu-		
	mentation of licensed nurses July 13 & 14 was reviewed.		

Name of Evaluator Toni Stratton, HFR-N

Signature of Evaluator Toni Stratton

State Department of Health Services
Licensing and Certification Division
50 D Street, Suite 330
Santa Rosa, CA 95404-47[illegible]

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature Adm.

Name

Title Administrator

Page 2 of 3 Page(s)

HS 816A1 (4/85)

HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER NUMBER 05-	(X2) MULTIPLE CONSTRUCTION: A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 71-23-85
NAME OF PROVIDER OR SUPPLIER Convalescent Hospital	STREET ADDRESS, CITY, STATE, ZIP CODE		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE

F128	Citation # 01H-233-032
	X-Ref Complaint # SR85-118-SB
	72311(3)(B)
	405.1124(c)
	Patient "D" is a 92 year old female admitted to the facility 3-22-85 with diagnosis of S/P C.V.A., diabetes, L hemiparesis. The medical record documentation of licensed nurses July 13 and 14 was reviewed.
	7-13 "... had emeses x2 of previously taken food..."
	3 PM later note "... didn't eat her food only took fluids..."
	714 10 AM "... emesis x1 after lunch with complaint of mild abdominal pain and clammy perspiration..."
	There was no documentation the physician was called.
	The patient was transferred to the acute hospital 7-14-85 at 1255 where she expired a few hours later.
		F128	F126
			1. All licensed nurses will be in-serviced on proper nursing assessment skills.
			2. The policy and procedure on timely notification of physicians will be reviewed with all nurses.
			3. The Nursing Care Coordinator will review skills of all new licensed staff oriented within one month of hire.
			4. Responsible nurses for untimely notification will be disciplined as appropiate.
				[illegible]
				07-28-85
				07-23-85
				07-28-85

APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE 07-24-85
APPROVED BY DHHS REGIONAL OFFICE ☐ DISAPPROVED BY DHHS REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)	DATE	TITLE Administrator	

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

Form HCFA-2567(11-80) (Formerly SSA-2567) 4. SURVEY STATE AGENCY Page ___ of ___

ECTION 1424 NOTICE SUPPLE T   Violation   ation Number(s):

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all he listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	72311(3)(B) - continued		
	7-13 ..." had emeses x2 of previously taken food..."		
	3 PM later note..." didn't eat her food only took		
	fluids'		
	7-14 10AM..." emesis x1 after lunch with complaint		
	of mild abdominal pain and clammy		
	perspiration..."		
	There was no documentation the physician was called.		
	The patient was transferred to the acute hospital		
	7-14-85 at 1255 where she expired a few hours later.		
	FAILURE TO NOTIFY THE ATTENDING PHYSICIAN PROMPTLY		
	OF ANY SUDDEN AND/OR MARKED ADVERSE CHANGE IN SIGNS,		
	SYMPTOMS OR BEHAVIOUR EXHIBITED BY A PATIENT HAS A		
	DIRECT OR IMMEDIATE RELATIONSHIP TO THE HEALTH,		
	SAFETY OR SECURITY OF THESE PATIENTS AND ALL THE		
	PATIENTS IN THE FACILITY.		

Name of Evaluator Toni Stratton, HFR-N

Signature of Evaluator Toni Stratton

State Department of Health Services
Licensing and Certification Division
50 D Street, Suite 330
Santa Rosa, CA 95404-47[illegible]

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature , Adm.

Name

Title Administrator

Page 3 of 3 Page(s)

HS 816Ai (4/85)

OMBUDSMAN PROGRAM
VOLUNTEER CENTER OF NAPA COUNTY, Inc.
1700 2ND ST., SUITE 308
NAPA, CALIFORNIA 94559 (707) 252-6222

August 22, 1985

Donald J. Yannetta
Regional Administrator
Department of Health Services
Licensing & Certification
2422 Arden Way, Bld. B, Suite 35
Sacramento, CA 95825

Dear Don,

I would like your guidance and help with an issue which is causing me grave concern. In regard to complaints against Convalescent Hospital in I have perceived a lack of an enforcement orientation by the Santa Rosa Licensing office, which we depend upon for back-up in relation to potentially serious complaints.

My immediate concern involves a complaint which I received on July 15, 1985 and referred on to Licensing the same day.

I would like to here present a chronology of events as I have perceived them, so that you may better understand my frustration:

July 15, 1985

Betty , daughter of patient Anna , called the Ombudsman office with a complaint about poor nursing care and negligence at Convalescent Hospital. The family feels that their mother's suffering and death are related to negligence and lack of response to their concerns, by the facility. Licensing notified by phone from Ombudsman office.

July 16, 1985

Deceased patient's daughters came to Ombudsman office, and I typed their statements verbatim. Please see enclosed statement.

L&C evaluator, Toni Stratton, returned our call and agreed to pick up complainants' statements next day.

Family informed me later that the patient's physician (and also the facility's Medical Director), Dr. , had refused to sign the patient's death certificate and requested an autopsy. The coroner's office performed the autopsy at 4:30 on Monday, July 15.

July 17, 1985

Toni Stratton, L&C evaluator, came by Ombudsman office, 9 AM, to pick up family's typed statement. She indicates is pursuing the investigation and will keep us informed. She said she wanted to be sure the investigation was thorough enough to uphold an "A" citation if the case warranted it.

July 23, 1985

Granddaughter of patient, Peggy Dowling, called: family was notified by the doctor that autopsy revealed an intestinal blockage. Family to get copy of autopsy report.

August 6, 1985

No feedback or further contact from Licensing concerning the case. I called L&C office because I was to go on vacation for 10 days beginning August 8, and I wanted to find out if a CRC would occur during my absence. I spoke with Mr. Shipley, administrator of the Santa Rosa office, who said that Licensing did find that the patient's doctor was not properly notified of the change in condition. He added that now they are thinking that the "B" citation issued by Toni Stratton should be changed to an "A".

This was the first I heard that this complaint was given only a "B" citation, and I immediately expressed my feeling that this had appeared to be much more serious issue than the "B" indicated. I was extremely surprised by this turn of events, especially since the evaluator and I had discussed the seriousness of the complaint.

Mr. Shipley said that he now felt that Toni may have looked at this case "too quickly", that she had not looked at all the reports (including the autopsy report) but that she will do so. He added that there was another very similar case occuring simultaneously, in which there was failure to report a patient's change of condition and in which the patient had expired (also a patient).

Mr. Shipley replied to my concern about missing a CRC between this date and August 19, that it was unlikely that it would come about that soon.

August 19, 1985

I returned from vacation to find a report from Licensing showing two "B" citations against and the notice of a CRC slated for August 15. Please see enclosed L&C reports.

My immediate reaction was to wonder why the same standards which seem to be in operation in other parts of the state (in which AA citations are being issued for very similar complaints) are apparently not being applied here.

August 21, 1985

I called Mr. Shipley, at Licensing, to ask why this case was so quickly determined to be only a "B" violation rather than an "A" or "AA".

In reference to my receipt of the "B" citation in the mail, Mr. Shipley said, "Something's happened since then." He explained how there were two cases which are very similar; one patient died the same day she went to the acute care hospital and the other died 4 days later. He said that in both cases, the doctor was not contacted by the facility when the patients exhibited unusual symptoms.

Mr. Shipley went on to say that two "B" citations were initially written. He then said that after writing the 2 B's the evaluator (Toni Stratton) received "additional information" about the cases, evidently from the ambulance drivers (whom Toni and I had discussed the need to interview) and from the ER room. Mr. Shipley said it was not until this "additional information" was uncovered that Licensing enlisted the services of their Physician Consultant. When I asked why the physician was not consulted with earlier, considering the seriousness of the complaint, he replied that the physician is not always available.

Mr. Shipley said that the reason the cases were originally set at a "B" level is because the evaluator had a difficult time relating the stated cause of death with the symptoms or with not notifying a doctor; but he added that now they feel these can be tied together.

I then asked why a more thorough investigation was not conducted before issuing the "B" citation, and mentioned that the evaluator and I had discussed the importance of talking with the ambulance drivers and getting all possible information in order to uphold a possible A or AA citation.

Mr. Shipley then said that they have "rescinded the B's, based on the new information, and have reopened the investigation." He added that they have yet to pull it all together, but that I would be notified of progress and results.

Mr. Yanetta, this is the most serious complaint I have forwarded to Licensing concerning Convalescent, but it is not the first time I have felt a reluctance to vigorously enforce regulations in this facility. In particular, eyewitness accounts by family members and friends of patients in this nursing home have historically not been given validity when they contradict what the facility administrative staff have to say.

I would welcome your involvement in this, and any advice you can give me concerning how to best work cooperatively with the Licensing agency to ensure protection of patients and adequate investigation of complaints made on their behalf.

Yours very truly,
Kristin Casey
Kristin Casey
Napa County Ombudsman Coordinator

cc: Esther Rains, State Ombudsman
Mary Hinchliff, CLCTOA President

HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

Citation

Ref Comp.

FORM APPROVED
OMB NO. 0938-0043

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 05-

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING ____
B. WING ____

(X3) DATE SURVEY COMPLETED: 08/28/85

NAME OF PROVIDER OR SUPPLIER: Convalescent Hosp.

STREET ADDRESS, CITY, STATE, ZIP CODE:

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
	CLASS "AA" VIOLATION			
F128	405.1124(c) 72311(3)(b) Nursing Service-General Nursing service shall include, but not be limited to the following: Notifying the attending physician promptly of: any sudden and/or marked adverse changes in signs, symptoms or behaviour exhibited by a patient. Patient "A" was a 92 year old female patient admitted to the facility on 3-22-85 with the following diagnosis: s/p C.V.A. - diabetes - Ⓛ hemiparesis A review of the medical record between 7-12-85 and 7-14-85 documented marked adverse changes in the signs and symptoms of this patient. The patient was transferred to the acute hospital on 7-14-85 @ 1255 where she expired a few hours later.		Prep and execution of this Plan of Correction does not constitute an admission or agreement by this facility of the truth of the facts alleged or conclusions set forth on the statement of deficiencies and is being prepared and excuted solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907. The facility has had and continues to have and follow a policy of notifying attending physicians promptly with respect to sudden and/or marked changes in patients. It will continue to inservice on periodic bases all staff with respect to the necessity of giving such timely notification. The Last inservice for this was on July 28, 1985. We have and will continue to monitor the skills of staff to determine their knowledge of these requirements. The Nursing Coordinator will be responsible for this.	10/30/85

APPROVED BY STATE CERTIFYING AGENCY ☐ DISAPPROVED BY STATE CERTIFYING AGENCY ☐	REVIEWED BY (INITIALS)	SF	DATE 10/30/85	PROVIDER REPRESENTATIVE'S SIGNATURE	X6 DATE
APPROVED BY DHHS REGIONAL OFFICE ☐ DISAPPROVED BY DHHS REGIONAL OFFICE ☐ (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)	REVIEWED BY (INITIALS)		DATE	TITLE	

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

Form HCFA-2567 (11-80) (Formerly SSA-2567)

4 SURVEY STATE AGENCY

Page ___ of ___

Citation #

T OF HEALTH, EDUCATION AND WELFARE
CARE FINANCING ADMINISTRATION

Form Approved
OMB No. [illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER 05-5332	(X2) MULTIPLE CONSTRUCTION A BUILDING ______ B WING ______	(X3) DATE SURVEY COMPLETED 8/28/85

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	72311(3)(b) continued There was no documentation that the attending physician was notified of the marked, adverse signs and symptoms of this patient. The physician's review of the medical record and autopsy report of Patient "A" determined a direct proximate relationship between lack of physician notification and the patient's subsequent expiration.			

HCFA-2567A (11-75) (FORMERLY SSA-2567A)

4. SURVEY STATE AGENCY

Page ______ of ______

[illegible] NOTICE — Violation or Citation Number(s): C1H ___, ___, ___, ___, ___

You are hereby found in violation of California Health and Safety Code, Division 2 and/or California Administrative Code, Title 22, Div. 5

LICENSEE	DATE August 28, 1985		TIME 1530 ☐ AM	
LICENSEE ADDRESS (STREET) Corporation (CITY)	TYPE OF OWNERSHIP Profit Corp. (STATE)	CAPACITY	TYPE OF VISIT Complaint	
FACILITY NAME Convalescent Hospital	FACILITY TYPE Skilled Nursing		FACILITY NUMBER	
FACILITY ADDRESS (STREET) (CITY)	(ZIP)		PHONE NUMBER	

Each citation will identify the code, title and section violated, the class of violation, the requirement of law or regulation, the nature and location of the violation and the time limit for correcting the violation.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	CLASS "AA" VIOLATION	$25,000.00	
72311(3)(B)	NURSING SERVICE - GENERAL		0900
	Nursing service shall include, but not be limited to the following: Notifying the attending physician promptly of: any sudden and/or marked adverse changes in signs, symptoms or behaviour exhibited by a patient.		8-30-85
	Patient "A" was a 92 year old female patient admitted to the facility on 03-22-85 with the following diagnosis: s/p C.V.A. - diabetes - Ⓛ hemiparesis. A review of the medical record between 7-12-85 and 7-14-85 documented marked adverse changes in the signs and symptoms of this patient. The patient was transferred to the acute hospital on 7-14-85 @ 1255 where she expired a few hours later.		
	There was no documentation that the attending physician was notified of the marked, adverse signs and symptoms of this patient.		

Name of Evaluator Toni Stratton, HFE-N

Signature of Evaluator T. Stratton

State Department of Health Services
Licensing and Certification Division
50 D Street, Suite 330
Santa Rosa, CA 95404-4758

Without admitting guilt, I hereby acknowledge receipt of the Citati Notice.

Signature ___

Name ___

Title adm. assist.

NOTE: In accordance with California Health and Safety Code, fai to correct violations is grounds for suspension or revocati of your license.

HS 816i (4/85)

Page 1 of 2 Page(s)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
3422 ARDEN WAY, BUILDING B
SUITE 35
SACRAMENTO, CA 95825
(916) 920-6851

September 4, 1985

Kristin Casey
Napa County Ombudsman Coordinator
1700 2nd Street, Suite 308
Napa, CA 94559

Dear Ms. Casey:

This is in response to your recent letter concerning complaints against the Convalescent Hospital in , and the Santa Rosa District Office.

As I indicated to you by phone, even before the receipt of your letter, I had already directed that the complaint and the "B" Citation be re-evaluated after it had come to my attention during my administrative review of the citation.

As further indicated to you, as a result of the re-evaluation, additional information and our Medical Consultant's review, the citation had been elevated from "B" to an "AA" Citation.

Please be assured that all complaints forwarded to the District Office will receive careful and thorough investigation and citations will be appropriately issued as the situation warrants.

You may be interested to know that the Division of Licensing and Certification has established a Program Review Team which has, as one of its responsibilities, the evaluation of District Office operations in order to assure that regulations and Department policies are interpretated uniformally statewide and to identify training needs. It is expected that the Santa Rosa District Office will be reviewed in the near future.

We look forward to your cooperation in assisting us to ensure that all patients in Health Facilities are protected.

Thank you for bringing your concerns to my attention. If I can be of further assistance, please contact me.

Sincerely,

DJYannetta
Donald J. Yannetta
Regional Administrator
Licensing & Certification Division
Northern California Region

cc: Esther Rains, State Ombudsman

January 22, 1985

TO: Little Hoover Commision

FROM: Peggy Dowling

SUBJECT: Statement Regarding Facilities Licensing

My name is Peggy Dowling. In July of 1985 I had reason to file a complaint with the Napa County Ombudsman Program. My Grandmother was a patient in a local nursing home. I feel that the lack of physician notification of the change of her condition on July 12 & 13 resulted in her death on July 14, 1985. Her doctor agreed that a complaint should be filed.

On July 16, 1985 my Mother and I filed a complaint. On July 23, 1985 a "B" citation was issued and the case was closed. I felt that the nursing home had only had their hands slapped.

I spoke with the evaluator within a few days of the citation being issued. I was told "In the time allowed for the investigation my findings did not warrant a "AA" citation. I asked how much time was allowed? I was quoted "10 days".

In the next couple of weeks during my telephone conversations with the evaluator, I certainly got the impression that she didn't feel good about the citation not being higher. I also got the impression that she felt it was out of her hands.

When I filed my complaint with the Ombudsman, a copy was sent to the Justice Dept. I feel strongly that because of this involvement questions were raised about the "B" citation. The result was the case was reopened and more evidence was found and the "B" citation was raised to a "AA" citation.

I'm glad about the outcome of this, but I have a concern about the time limit for the investigation. In my case 10 days just wasn't enough time. It resulted in a incomplete investigation and a lower citation then was warranted. My remaining concern is that I haven't heard anything from State Licensing since August 8, 1985. I have no idea where the case stands, when or if it will ever go to court, and more importantly if the nursing home will ever have to pay the fine. The nursing homes need the laws to be enforced to insure proper care for the elderly. Thank you.

Sincerely,

Peggy Dowling

Peggy Dowling

5266 Old Sonoma Rd

Napa, CA. 94558

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(916) 322-9193

Ms. Peggy Dowling
5265 Old Sonoma Road
Napa, CA 94558

Dear Ms. Dowling:

This is in response to your letter of January 22, 1986, addressed to the "Little Hoover Commission", and the concerns you expressed regarding the investigation of your grandmother's death.

Please accept our apology for not keeping you informed of the current status of the investigation involving your complaint against Convalescent Hospital.

I have requested Erv Shipley, District Administrator of the Santa Rosa District Office, to send you copies of the Statement of Deficiencies on the "AA" citation that was issued to the facility regarding the death of your grandmother.

If you have further questions, please do not hesitate to contact Mr. Shipley at the Santa Rosa District Office, 50 D Street, Room 330, Santa Rosa, CA 95404, (707) 576-2380.

Sincerely,

Paul H. Keller

Paul H. Keller, Chief
Field Operations Branch
Licensing and Certification

cc: Erv Shipley
Santa Rosa District Office

K. Casey
Napa County Ombudsman
Coordinator

Chairman **Heinz**. Ms. Dowling, first we thank you for coming back here. It is a long way from Napa, either Sacramento or San Francisco, to come back to Washington, DC. And it is particularly hard under the circumstances that you have described you were experiencing and still obviously are very much feeling the effects of. You are a courageous woman to do that.

Ms. **Dowling**. Thank you. This is for Gram. I have to say I am doing this for Gram.

Chairman **Heinz**. I am also sure that your two California Senators, Pete Wilson and Alan Cranston, will be very much interested in this situation and will want to assist you in pursuing it with the appropriate State authorities.

There is one other matter that concerns me also about your case. You did mention that the citation had been upgraded to "AA" and a $25,000 fine. We checked into that, and we find that that fine is yet to be collected from that nursing home.

Ms. **Dowling**. They told us that they would appeal it, and it would go into a court in Napa. When I asked when, I was told it could be any time within a year, 2 years.

Chairman **Heinz**. So you are aware of the fact that the fine is still in the pockets of the nursing home.

Ms. **Dowling**. That is why I keep in very close contact with the Ombudsman Program.

Chairman **Heinz**. You know, these are often kind of cold statistics up there, behind Senator Nickles and Senator Cohen, when it says, "Facility failed to provide adequate physician supervision of patients," or "Facility failed to provide adequate 24-hour nursing care," and that is where you have a nurse that knows what is going on. And apparently, in your case, that was not at all the situation. Those statistics take on very real, live, flesh-and-blood meaning.

Ms. **Dowling**. Senator Heinz, I would like to say something. The day after my grandmother died, I went back to the convalescent hospital and asked them what their procedure was on calling a doctor when it became apparent that it was necessary. The excuse I was given was that the nurse was "new, and only a weekend nurse".

So I agree with Senator Pryor—after hours and on weekends, the things that go on—and they do know when the evaluators are coming. As soon as we walked in the door, we could tell. Everybody had their restraining belts on; they were clean; people were bustling around, looked busy.

Chairman **Heinz**. And it is probably true that the best staff, the most experienced staff, the most senior staff, would rather work during the day than on the night shift or the graveyard shift.

Ms. **Dowling**. Yes.

Chairman **Heinz**. Thank you very much, Ms. Dowling.

Senator **Pryor**. May I make a comment, Mr. Chairman?

Chairman **Heinz**. By all means.

Senator **Pryor**. Ms. Dowling has really underlined a problem of so many nursing home patients, and the families especially, and that is the absolute fear of registering a complaint because of repercussions or reprimands against the patient if a complaint is raised. I hope that Dr. Roper is listening to this, because that in itself is one of the more grave problems that we have. It is a serious issue, that is absolute fear, because the nursing home can turn you out, they can put you in, as you say, another part of the facility. They can do many, many things to you, and no one will know about it.

I appreciate your bringing that point up, because that problem certainly exists.

Thank you, Mr. Chairman.

Chairman HEINZ. Thank you, Senator Pryor.

Senator NICKLES. Mr. Chairman.

Chairman HEINZ. Senator Nickles, by all means. Just let me explain.

Senator NICKLES. I hear you.

Chairman HEINZ. I wanted to go through the panel of witnesses now, but if you have a comment or an opening statement——

STATEMENT BY SENATOR DON NICKLES

Senator NICKLES. If you do not mind, I do not have any questions for the panelists, and I apologize for the fact that we are having an energy markup, and my staff is telling me they need me to scout. So I want to congratulate you and compliment you on having this hearing. I think the additional focus and exposure, if nothing else, will hopefully highlight some of the problems and help bring about enough pressure throughout the country.

I think the statistics that you have shown on the chart indicate that we do have a problem throughout the country. So I compliment you for it, and maybe with enough exposure, pressure, and attention focused on the problem, we can help improve the quality of health care throughout a lot of the nursing homes throughout the country.

So I compliment you for the hearing, and I apologize for the fact that I need to excuse myself.

Chairman HEINZ. Senator Nickles, thank you very much for joining us.

Let me call on our next witness, Mr. Ralph Lopez, who runs a very aggressive nursing home compliance program, I am told, in Los Angeles. He will offer as part of his testimony a videotape—that is why we have these monitors—and I know that that videotape documents some really shocking conditions inside nursing homes in Los Angeles County.

Mr. Lopez, please proceed.

STATEMENT OF RALPH LOPEZ, CHIEF, HEALTH FACILITIES DIVISION, COUNTY DEPARTMENT OF HEALTH SERVICES, LOS ANGELES, CA

Mr. LOPEZ. Good morning, Senator Heinz.

I am Ralph Lopez, chief of the health facilities division for Los Angeles County. The health facilities division is responsible for the inspection of health facilities and other various ancillary services for State licensure.

As a representative of the State agency, we also inspect providers for compliance with Medicare and Medicaid regulations for the appropriate Federal agency.

I have been involved in these programs for the last 20 years, first as a surveyor since the inception of Medicare in 1966; then, as a district supervisor, and presently as the chief of the division for at least the last 10 years.

Los Angeles County has approximately 400 nursing homes, caring for approximately 40,000 patients. This represents approximately one-third of California's total nursing homes and patient population.

Our experience shows that nursing homes fall into three broad categories—first, as was stated this morning, those in superior care—and the problem with that is that there probably are anywhere from 2- to 3-year waiting lists to get into the superior care facilities, second, facilities that, although providing minimum level of acceptable care, are in need of some form of constant and repeated monitoring. Most of the facilities seem to fall into this category. And then, third, facilities that repeatedly violate regulations, jeopardizing the health and safety of patients. These comprise probably 10 percent, but they require a very disproportionate allocation of manpower and legal resources.

In 1976, Los Angeles County determined that there was a need to coordinate enforcement and develop a coordinated enforcement program to deal with nursing home problems. A special unit was created within the division to monitor and provide enforcement expertise for specific division activities that were separate and apart from routine inspection functions.

The activities of the unit were and continue to be focused on evidence gathering, prosecution, and liaison with enforcement agencies and licensing boards.

It was clear to us that an investigation of rape, assault, or theft within health facilities required the same expertise on the same level as if the crimes occurred at some other location.

As a matter of county policy and actual practice, the health facilities division works closely and shares information on a routine basis with the chief medical examiner-coroner, the public guardian, and the office of the district attorney-nursing home abuse section. This allows for close review and monitoring of cases and enhances our coordinated efforts. It enhances the effort to prosecute individuals for specific criminal acts as well as owners and operators of nursing homes who willfully and repeatedly offer substandard care.

Although the overall quality of care at nursing homes has improved over the years, due largely, I think, to an increase in public awareness and concern, the highly vulnerable patient population continues to be subjected to a variety of outrageous sexual, physical, and financial abuses.

Some of the cases we have investigated and/or prosecuted with the assistance of the Los Angeles County District Attorney's Office include: A nurse's aide who forced an 82-year-old female patient into an act of oral copulation; a nurse's aide who was caught in the act of raping a 34-year-old female brain-impaired nursing home patient; a licensed vocational nurse who had intercourse with a 41-year-old female nursing home patient—our investigation showed that this very same nurse had been previously involved in aberrant sexual advances to another elderly comatose patient; the case of a 35-year-old brain-impaired female nursing home patient who was discovered to be pregnant—the patient was bedridden and oblivious to her surroundings; a nurse's aide who allegedly abused a 74-year-old male patient to such an extent that he caused a massive subdural hematoma resulting in the patient's death. The nursing home denied any liability, claiming that the death was caused by natural causes. A coroner's inquest jury voted to change the death certificate from "accidental" to "death at the hands of another."

Cases of financial abuse, in our experience, have diminished in the past few years. However, the following recent case illustrates the need for continued surveillance.

A nursing home ordered a $692 television set for a patient without knowledge or specific authorization of that patient. The money for the set was obtained from the patient's personal trust account. Upon delivery, the television was placed in the facility closet and obviously soon disappeared. Aside from the blatant dishonesty involved, what makes this case tragic is that the patient was totally blind.

Patients' private funds held in trust by a nursing home are by law to be delivered to designated relatives upon death of patients, but oftentimes the families are unaware that the money is held in trust. And if the family fails to make an affirmative demand, the funds are siphoned off by the nursing homes.

A continuing challenge regarding the inspection of nursing homes is the so-called inspection window of predictability. Facilities generally can predict when they are due for an inspection, and they can undertake measures to assure that the facility is at its highest level of compliance. Consequently, the inspection findings may not be representative of the actual conditions.

I would note that we are now surveying all work shifts in Los Angeles County.

Recently, during the course of a routine inspection, our records disclosed information about a 76-year-old patient with bedsores. The records were really unremarkable, and the facility was apparently providing appropriate care, at least according to the records. However, our inspectors had previously obtained earlier photocopies of the record, and a comparison of the two disclosed extensive falsification of the record.[15]

Other violations included inadequate number of staff to adequately supervise and meet the needs of the patients.

Facilities know when their Medicare and Medicaid contracts expire, and that is a key point. They also know that the facility must be inspected prior to the issuance of a new provider agreement, which is approximately 30 days. So, we strongly recommend that greater emphasis be placed on truly unannounced and random inspections.

You will view a videotape taken at our request by Mr. Leland Harris of the Los Angeles County District Attorney's Office, while on an unannounced visit to a facility. Although the conditions depicted in the tape may not be typical of all nursing homes, they are reflective of conditions that are unfortunately all too common.

[Videotape shown.]

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[15] "Please see volume I, appendix 3, page 625."

Chairman HEINZ. Pretty tough stuff. And that is, you say, not uncommon?

Mr. LOPEZ. Well, one of our problems is the distance between reviewers and courts and people who terminate contracts on any level, State or Federal Governments, not really accepting what surveyor-inspectors say about conditions. And this effort was the advanced effort of our trying to get into videotaping—modern, high-technology evidence gathering—so that we will be able to demonstrate to either criminal courts or administrative hearings and others who really do not hear and feel and see what is going on.

[The prepared statement of Mr. Lopez follows:]

TESTIMONY BY RALPH LOPEZ

CHIEF, HEALTH FACILITIES DIVISION

LOS ANGELES COUNTY

DEPARTMENT OF HEALTH SERVICES

BEFORE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

JOHN HEINZ, CHAIRMAN

MAY 21, 1986

GOOD MORNING.

I AM RALPH LOPEZ, CHIEF OF HEALTH FACILITIES DIVISION FOR THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES.

HEALTH FACILITIES DIVISION IS RESPONSIBLE FOR THE INSPECTIONS OF HEALTH FACILITIES AND VARIOUS ANCILLARY SERVICES FOR STATE LICENSURE. AS A REPRESENTATIVE OF THE STATE AGENCY, WE ALSO INSPECT PROVIDERS FOR COMPLIANCE WITH MEDICARE AND MEDICAID REGULATIONS AND MAKE APPROPRIATE RECOMMENDATIONS REGARDING CERTIFICATION STATUS TO THE BUREAU OF HEALTH STANDARDS AND QUALITY, HEALTH CARE FINANCE ADMINISTRATION, HEALTH AND HUMAN SERVICES.

I HAVE BEEN INVOLVED IN THESE PROGRAMS FOR THE LAST 20 YEARS. FIRST AS A SURVEYOR SINCE THE INCEPTION OF MEDICARE, THEN AS A DISTRICT SUPERVISOR AND PRESENTLY AS CHIEF OF THE DIVISION.

LOS ANGELES COUNTY HAS 389 NURSING HOMES CARING FOR APPROXIMATELY 40,000 PATIENTS. THIS REPRESENTS APPROXIMATELY ONE-THIRD OF CALIFORNIA'S TOTAL NURSING HOMES AND PATIENT POPULATION.

OUR EXPERIENCE SHOWS THAT NURSING HOMES FALL INTO 3 BROAD CATEGORIES:

1. FACILITIES THAT EXCEED MINIMUM STANDARDS AND PROVIDE ABOVE AVERAGE CARE. WE ESTIMATE THAT APPROXIMATELY 20% OF OUR FACILITIES ARE IN THIS CATEGORY

2. FACILITIES THAT ALTHOUGH PROVIDING MINIMUM LEVEL OF ACCEPTABLE CARE, ARE IN NEED OF SOME FORM OF CONSTANT AND REPEATED MONITORING. MOST OF THE FACILITIES WITHIN

OUR PURVIEW FALL WITHIN THIS GENERAL CATEGORY.

3. FACILITIES THAT REPEATEDLY VIOLATE REGULATIONS JEOPARDIZING THE HEALTH AND SAFETY OF PATIENTS. SAID FACILITIES ALTHOUGH COMPRISING OF ONLY A MINORITY OF THE TOTAL NUMBER OF FACILITIES REQUIRE A DISPROPORTIONATE ALLOCATION OF MANPOWER AND LEGAL RESOURCES TO MONITOR. WE ESTIMATE THAT APPROXIMATELY 10% OF THE FACILITIES FALL INTO THIS CATEGORY.

IN 1976, LOS ANGELES COUNTY DETERMINED THAT THERE WAS A NEED FOR A COORDINATED ENFORCEMENT PROGRAM TO DEAL WITH NURSING HOME PROBLEMS. A SPECIAL UNIT WAS CREATED WITHIN THE DIVISION TO MONITOR AND PROVIDE ENFORCEMENT EXPERTISE FOR SPECIFIC DIVISION ACTIVITIES THAT WERE SEPARATE AND APART FROM THE ROUTINE INSPECTION FUNCTIONS. THE ACTIVITIES OF THE UNIT WERE AND CONTINUE TO BE FOCUSED ON EVIDENCE GATHERING, PROSECUTION AND LIAISON WITH ENFORCEMENT AGENCIES AND LICENSING BOARDS. IT WAS CLEAR TO US THAT AN INVESTIGATION OF RAPE, ASSAULT OR THEFT

WITHIN HEALTH SETTINGS REQUIRED EXPERTISE ON THE SAME LEVEL AS IF THE CRIMES OCCURRED AT SOME OTHER LOCATION.

AS A MATTER OF COUNTY POLICY AND ACTUAL PRACTICE, THE HEALTH FACILITIES DIVISION WORKS CLOSELY AND SHARES INFORMATION ON A ROUTINE BASIS WITH THE CHIEF MEDICAL EXAMINER-CORONER, THE PUBLIC GUARDIAN, AND THE OFFICE OF THE DISTRICT ATTORNEY-NURSING HOME ABUSE SECTION.THIS ALLOWS FOR CLOSE REVIEW AND MONITORING OF CASES AND ENHANCES THE COORDINATED EFFORTS TO PROSECUTE INDIVIDUALS FOR SPECIFIC CRIMINAL ACTS AS WELL AS OWNERS AND OPERATORS OF NURSING HOMES WHO WILLFULLY OR REPEATEDLY OFFER SUBSTANDARD CARE.

ALTHOUGH THE OVERALL QUALITY OF CARE IN NURSING HOMES HAS IMPROVED OVER THE YEARS-DUE LARGELY TO AN INCREASE IN PUBLIC AWARENESS AND CONCERN--THE HIGHLY VULNERABLE PATIENT POPULATION CONTINUES TO BE SUBJECTED TO A VARIETY OF OUTRAGEOUS SEXUAL, PHYSICAL AND FINANCIAL ABUSES.

SOME OF THE CASES WE HAVE INVESTIGATED AND OR PROSECUTED WITH THE ASSISTANT LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE INCLUDE:

A) A NURSES AIDE WHO FORCED AN 82-YEAR-OLD FEMALE PATIENT INTO AN ACT OF ORAL COPULATION.

B) A NURSES AIDE WHO WAS CAUGHT IN THE ACT OF RAPING A 34-YEAR-OLD FEMALE BRAIN-IMPAIRED NURSING HOME PATIENT.

C) A LICENSED VOCATIONAL NURSE WHO HAD INTERCOURSE WITH A 41-YEAR-OLD FEMALE NURSING HOME PATIENT. OUR INVESTIGATION SHOWED THAT THIS SAME NURSE WAS INVOLVED IN ABERRANT SEXUAL ADVANCES TO A 77-YEAR-OLD COMATOSE FEMALE PATIENT FIVE YEARS EARLIER.

D) THE CASE OF A 35-YEAR-OLD BRAIN IMPAIRED FEMALE NURSING HOME PATIENT WHO WAS DISCOVERED TO BE PREGNANT. THE PATIENT WAS BEDRIDDEN AND OBLIVIOUS TO HER SURROUNDINGS.

E) A NURSES AIDE WHO ALLEGEDLY ABUSED A 74-YEAR-OLD MALE PATIENT TO SUCH AN EXTENT THAT HE CAUSED A MASSIVE SUBDURAL HEMATOMA RESULTING IN THE PATIENT'S DEATH. THE NURSING HOME DENIED ANY LIABILITY CLAIMING THAT THE DEATH WAS CAUSED BY NATURAL CAUSES. A CORONER'S INQUEST JURY VOTED TO CHANGE THE DEATH CERTIFICATE FROM "ACCIDENTAL" TO "DEATH AT THE HANDS OF ANOTHER".

CASES OF FINANCIAL ABUSE IN OUR EXPERIENCE HAVE DIMINISHED IN THE PAST FEW YEARS. HOWEVER, THE FOLLOWING RECENT CASE ILLUSTRATES THE NEED FOR CONTINUED SURVEILLANCE. A NURSING HOME ORDERED A $692 TELEVISION SET FOR A PATIENT WITHOUT THE KNOWLEDGE OR SPECIFIC AUTHORIZATION OF THAT PATIENT. THE MONEY FOR THE SET WAS OBTAINED FROM THE PATIENT'S PERSONAL TRUST ACCOUNT. UPON DELIVERY, THE TELEVISION SET WAS PLACED IN A FACILITY CLOSET AND SOON DISAPPEARED. ASIDE FROM THE BLATANT DISHONESTY INVOLVED, WHAT MAKES THIS CASE TRAGIC IS THAT THE PATIENT WAS TOTALLY BLIND.

A CONTINUING CHALLENGE REGARDING THE INSPECTION OF NURSING HOMES IS THE SO-CALLED INSPECTION "WINDOW OF PREDICTABILITY". FACILITIES GENERALLY CAN PREDICT WHEN THEY ARE DUE FOR AN INSPECTION AND CAN UNDERTAKE MEASURES TO ASSURE THAT THE FACILITY IS AT AN OPTIMAL LEVEL OF COMPLIANCE. CONSEQUENTLY, THE INSPECTION FINDINGS MAY NOT BE REPRESENTATIVE OF THE ACTUAL CONDITIONS AT THE FACILITY. RECENTLY, DURING THE COURSE OF A ROUTINE VISIT OUR INSPECTORS NOTED INITIALLY THAT THE RECORDS OF A 76 YEAR OLD PATIENT WITH BEDSORES WAS UNREMARKABLE AND THE FACILITY WAS APPARENTLY PROVIDING APPROPRIATE CARE. HOWEVER, OUR INSPECTORS HAD PREVIOUSLY OBTAINED EARLIER PHOTOCOPIES OF THE RECORD AND A COMPARISON OF THE TWO DISCLOSED EXTENSIVE FALSIFICATION OF THE RECORD.

TRULY UNANNOUNCED AND RANDOM INSPECTIONS HAVE DEMONSTRATED EVIDENCE OF PATIENT NEGLECT AND POOR CARE. PATIENTS HAVE BEEN OBSERVED TO SIT OR LIE IN THEIR BODY WASTE FOR EXTENDED PERIODS OF

TIME. OTHER VIOLATIONS INCLUDED INADEQUATE NUMBER OF STAFF TO ADEQUATELY SUPERVISE AND MEET THE NEEDS OF THE PATIENTS.

FACILITIES KNOW WHEN THEIR MEDICARE AND/OR MEDICAID CONTRACTS EXPIRE AND THEY ALSO KNOW THAT THE FACILITY MUST BE INSPECTED PRIOR TO THE ISSUANCE OF A NEW PROVIDER AGREEMENT. WE STRONGLY RECOMMEND THAT GREATER EMPHASIS BE PLACED ON TRULY UNANNOUNCED AND RANDOM INSPECTIONS.

YOU WILL VIEW A VIDEO TAPE TAKEN AT OUR REQUEST BY MR. LELAND HARRIS OF THE LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE, NURSING HOME ABUSE SECTION, WHILE ON AN UNANNOUNCED VISIT TO A FACILITY. ALTHOUGH THE CONDITIONS DEPICTED IN THE TAPE MAY NOT BE TYPICAL OF ALL NURSING HOMES, THEY ARE REFLECTIVE OF CONDITIONS THAT ARE UNFORTUNATELY ALL TOO COMMON.

Chairman HEINZ. Let me turn to Ms. Casper. Before you begin your testimony, Ms. Casper, let me ask you, you are a former nursing home administrator, I understand; is that right?

Ms. CASPER. Yes.

Chairman HEINZ. Could you give us your impression of what we just saw?

Ms. CASPER. Yes. I not only am a nursing home administrator, I am also a registered nurse. I have spent the last 15 years of my career dealing with a wide variety of long-term care issues, both from the provider's side as a director of nursing as well as the regulator's side as an inspector, and a researcher in long-term care. I believe the film stands on its own merit. It has a very deep and profound effect on me. I guess it goes without saying that now is not the time to perhaps rest on our laurels; if we have made progress there is a long way to go.

Chairman HEINZ. Do you want to proceed with your statement?

STATEMENT OF SANDRA K. CASPER, PRESIDENT, REHABILITATION CARE CONSULTANTS, MADISON, WI

Ms. CASPER. I would be happy to, thank you.

My name is Sandra Casper, I am a registered nurse and a licensed nursing home administrator. I am president of Rehabilitation Care Consultants, which is a health care consulting firm located in Madison, WI.

We have been very involved with a wide variety of long-term care issues since 1980. RCC is in a very unique position in that we have evaluated four of the six State survey demonstrations that HCFA has funded. In addition, we evaluated the new PACS process that you heard referenced earlier today in the 47 nondemonstration States across the country this past year.

Thus, I feel that we are in a unique position, and we have some semblance of knowledge, I hope, about what works and what does not work in a regulatory process. So, for whatever value I can bring to the committee in its very important task today, I am happy to be here.

Much time, attention, and fiscal resource has been given to the issue of the provision of quality care to residents in our Nation's nursing homes—and rightly so. As demographics clearly tell us, our population is aging, and the quality of long-term care is a basic expectation that indeed deserves national attention.

The question then becomes, where do we find the long-term care delivery system today, and what is the result of the resource allocation that we have already given to this very important issue to date?

RCC and its staff have now traveled to over 30 States, evaluating long-term care issues on a wide variety of fronts, both from the provider and the regulatory perspective. These experiences have led us to believe that more can, and, indeed, should be done to ensure that all residents of long-term care facilities receive the quality and type of care to which they are entitled, and indeed, for which we all pay.

In the State where I am from, the State of Wisconsin, we have made a great deal of progress on this front. However, this progress is not consistently evident on a national level.

While there are obviously some very excellent long-term care facilities across the Nation that truly care about the residents for whom they are responsible, problem facilities still exist. Thus, I believe it is critical that we continue to press ahead with identification, and, more importantly, correction, of the causes of these chronically substandard facilities.

So what are these problems and what can we do to fix them?

Perhaps the best way for me to attempt to briefly answer some of these questions is to develop several very real case scenarios for you and attempt to address the question of why they occurred. There is clearly no need for me to draw from hypothetical or theoretical cases. My staff and I have plenty of real life case situations from which to draw.

For example, in one State, a facility was accepting residents for admission that they simply were unable to care for. One resident who was receiving her nutrition through a nasogastric tube, continued to lose weight, developed bedsores all over her body, including her ears, and finally weakened to the point of hospital admission and death.

It was found upon review of her medical records that her physician's order for the number of calories she was to receive each day was so low that it was deemed to be below the starvation rate by the nutritionist who evaluated the record.

In another facility, a resident was left unattended in a bathtub by an untrained nursing assistant, and the resident drowned.

How and why do these situations occur? Simply, the nursing staff at these facilities did not know enough about the residents for whom they were responsible to care for them in an appropriate and professionally acceptable fashion.

In another State, while RCC was onsite evaluating the application of a State licensure and Federal certification survey process, RCC observed that the State inspector found no deficiencies to be present in the facility, that we were in.

However, it was the opinion of the RCC staff, based on such examples as a newly admitted stroke patient who was not receiving physical therapy and thus was already developing contractures of both his upper and lower extremities after less than a week of residency in this facility, that this decision was in error. The situation was brought to the attention of the State agency by RCC, as we felt a moral and ethical responsibility to do so, even though it clearly was outside our research design.

The State responded by sending in another inspector who agreed with RCC and overturned the decision of the initial inspector.

To take this one step further the Federal "look behind" option was implemented in this facility as well. The Federal inspectors obviously also agreed with RCC since they declared a state of jeopardy to exist in this facility. However, no Federal followup occurred to be sure that correction of these situations took place until over 60 days later.

How could these situations occur?

Survey staff were simply not able to detect potentially life-threatening resident care issues. This, coupled with very lengthy Federal intervention, led to the noncorrection and noncompliance of very severe resident-specific problems that, in our opinion, threatened the life and safety of the residents in this particular facility.

My last example is related to a facility where resident needs consistently are not met. To me, this is an example of a "chronically substandard" nursing home that continues to operate because there are no legal remedies available to the survey and certification agencies.

Residents with huge, open, infected bedsores are in the same room, and cross-contamination of the infections is occurring because the staff does not employ proper isolation techniques and are not trained to implement these highly skilled procedures. Untrained nursing assistants were observed, moving from patient to patient, changing their dressings, not washing their hands between patients, using one patient's medication for another, and generally functioning in a totally unacceptable fashion.

In addition, the water temperature was so low in this facility that proper aseptic technique was indeed even physically impossible to attain.

Again we ask the question: How does this happen?

The Federal Government has delegated much of its responsibility for enforcement of these issues to the State agencies. However, the State agencies tell us that these cases persist because they have no appropriate legal remedy available to them if they attempt to litigate these types of very resident-specific issues.

In essence, I have laid out problems in four basic areas that must be addressed before we feel we have at least begun to do our job in assuring quality of care and, just as importantly, quality of life to the residents in our Nation's long-term care facilities.

Point No. 1: Staff in nursing homes must be competent and able to care for the residents for whom they are responsible. This requires adequate reimbursement to facilities to attract and hire such staff, as well as an upgrading of the image of the staff that work in our Nation's long-term care facilities.

Point No. 2: State and Federal inspectors must be highly skilled and knowledgeable in the state of the art of long-term care. This requires much more stringent hiring, training and supervision of these very important key personnel.

Point No. 3: The Federal system of monitoring State inspection performance is not consistent between Federal regions and does not always result in strong Federal sanctions against problem facilities. This requires a role definition and consistent application of this definition at the Federal level.

My fourth and final point: Enforcement of regulation in a consistent and fair fashion is a very effective way of correcting problems in nursing homes. States with strong enforcement sanctions, my home State of Wisconsin being one, will surely attest to this fact.

However, this requires laws that will stand up in court and put the poor providers out of business, as well as laws that are not arbitrary and capricious and tie up many hours of both provider and regulator time in court on nonsubstantive, trivial, paper compliance kinds of issues.

This kind of litigation carries a huge cost to all concerned, but most importantly to the residents of our Nation's long-term care facilities.

Thank you very much for the opportunity to appear before you this morning.

[The prepared statement of Ms. Casper follows:]

Testimony of

SANDRA K. CASPER

before the

U.S. SENATE SPECIAL COMMITTEE ON AGING

May 21, 1986

Much time, attention, and fiscal resource has been given to the issue of care provision to residents of our nation's nursing homes -- and rightly so. As demographics clearly tell us, our population is aging and the provision of quality long term care is a basic expectation that indeed deserves national attention.

The question thus becomes, then, where do we find the long term care delivery system today? What is the result of the resource allocation that has been given this issue to date?

Rehabilitation Care Consultants, Inc. (RCC) and its staff have traveled to 30 states in a variety of roles -- evaluating both providers and regulators. These experiences have led us to believe that more can and should be done to ensure that all residents of long term care facilities receive the quality and type of care to which they are entitled.

In my home state, we have made a great deal of progress toward improving quality of care by strengthening enforcement of standards. Unfortunately, this progress has not been paralleled in the rest of the country. We must press ahead with identification and correction of several problems that still exist.

So what are these problems and what can we do to "fix" them? Perhaps the best way to answer these questions is to develop several very real case scenarios for you and attempt to address the question of why they occurred. There is no need to deal with hypothetical or theoretical cases when we have plenty of real life cases from which to draw.

For example, in one State a facility was accepting residents for admission that they were simply unable to care for. One resident, who was receiving her nutrition through a naso-gastric tube continued to lose weight, develop bedsores all over her body, including her ears, and finally weakened to the point of hospital admission and death. It was found that her physician's order for the number of calories she was to receive each day was so low that it was at the starvation rate. In another facility, a resident was left unattended in a bath tub by an untrained nursing assistant and the resident drowned. How and why did these situations occur? The nursing staff at these facilities simply did not know enough about the residents for whom they were responsible to care for them in an appropriate and professionally acceptable fashion.

In another State, while evaluating the application of a state licensure and Federal certification survey, RCC observed that the surveyor found no deficiencies to be present in this facility. But it was the opinion of the RCC staff, based upon such problems as a newly admitted stroke patient who was not receiving physical therapy and thus was already developing contractures of his upper and lower extremities, that this decision was in error. The situation was brought to the attention of the State agency by RCC, as we felt a moral and ethical responsibility to do so. The State responded by sending in another surveyor who agreed with RCC and over turned the decision of the initial surveyor. To take this one step further, the Federal look behind option was implemented in this facility as well. The federal surveyors apparently also agreed with RCC since they decided a state of jeopardy existed in this facility. However, no Federal follow up occurred to be sure correction of these situations took place until over 60 days later.

How could these situations occur? Survey staff was simply not able to detect potentially life threatening resident care issues. This, coupled with lethargic Federal intervention, led to the noncorrection and noncompliance of very severe problems that threatened the life and safety of residents.

My last example is related to a facility where resident needs consistently are not met. This to me is an example of a "chronically substandard" nursing home. This facility continues to operate because there are no legal remedies available to the survey and certification agency. At this facility, residents with huge, open, infected bedsores are in the same room and cross contamination of the infections is occurring because staff does not employ proper isolation techniques and are not trained to implement these highly skilled techniques. Untrained nursing assistants were observed moving from patient to patient changing their dressings, not washing their hands between patients, using one patient's medications for another, and generally functioning in a totally unacceptable fashion. In addition, the water temperature was so low in this facility that proper aseptic technique was indeed physically impossible to attain.

How does this happen? The Federal government has abrogated it's responsibility for enforcement and has left this job to theStates. However, state agencies say these cases persist because they have no appropriate legal remedy available to them if they attempt to litigate these types of problems.

In essence, I have laid out problems in four basic areas that must be addressed before we can feel we have done our job in assuring quality of care and quality of life to the residents of our nation's long term care facilities.

1. Staff in nursing homes must be competent and able to care for the residents for whom they are responsible. This requires adequate reimbursement to facilities to attract and hire such staff and an upgrading of the image of the staff that work in our nation's nursing homes.

2. State and Federal nursing home inspectors must be highly skilled and knowledgeable in the state-of-the-art of long term care. This requires more stringent hiring, training, and supervision of these very important personnel.

3. The federal system of monitoring state inspection performance is not consistent between regions and does not always result in strong Federal sanctions against problem facilities. This requires a job definition and consistent application of this definition at the national/Federal level.

4. Enforcement of regulation in a consistent and fair fashion is a very effective way of correcting problems in nursing homes. States with strong enforcement laws will surely attest to this fact. This requires laws that will stand up in court and put the poor providers out of business, as well as laws that are not arbitrary and capricious and tie up many hours of both provider and regulator time in court on nonsubstantive issues, at a huge cost to all concerned, most importantly, the residents of our nation's long term care facilities.

Chairman **Heinz**. Ms. Casper, I think Senator Cohen has a comment.

Senator **Cohen**. Just one quick question. You gave an example of one patient who died, I take it, as a result of malnutrition.

Ms. **Casper**. Yes.

Senator **Cohen**. Was any action ever taken by the facility or by the relatives of that patient against the doctor?

Ms. **Casper**. In fact, most of the cases that I referenced are under litigation at this time. Yes, action is currently underway on all of the instances.

Senator **Cohen**. But how did the action come about? Did the facility itself take action against the physician, or was it forced by the State or by an administrator?

Ms. **Casper**. In the particular one you referenced, where the woman was receiving a 600-calorie-a-day diet, action was brought by the district attorney for the State against the facility.

Senator **Cohen**. But the facility took no action itself?

Ms. **Casper**. No, it did not. In fact, they litigated.

Chairman **Heinz**. Thank you, Senator Cohen.

Mr. Thompson.

STATEMENT OF CONRAD THOMPSON, DIRECTOR, WASHINGTON BUREAU OF NURSING HOME AFFAIRS, OLYMPIA, WA

Mr. **Thompson**. Mr. Chairman, committee members, my name is Conrad Thompson. I am the director of the bureau of nursing home affairs for the State of Washington. The bureau is responsible for licensure and certification of nursing homes. In addition, the bureau is responsible for the Federal utilization, control, and inspection of care requirements and the setting of nursing home payment rates for Medicaid recipients.

The State has about 300 nursing homes with a total of 27,000 beds, of which 60 percent are occupied by Medicaid recipients.

I am going to briefly testify on the following topics: The new Federal nursing home inspection process, the need for adequate funds to inspect nursing homes, the need for key enforcement sanctions, the new Federal termination procedures, the continuing problem of Medicaid discrimination against Medicaid recipients, and national training standards for nursing assistants.

First, in late 1984, the U.S. Court of Appeals in a landmark case found for the plaintiffs, *Smith and the State of Colorado* v. *Heckler*, then Secretary for the Department of Health and Human Services. The court determined that the present Federal survey process does not judge quality of resident care.[16]

In response partly to the court's ruling, we have the new developed Federal nursing home inspection process, formerly called PACS. I understand the implementation date has now been moved up to July 1, 1986. The new process focuses on patients, rather than the facility's capacity and compliance with paper requirements. In this respect it is a significant step forward. However, the process has fundamental flaws. To make it a valid and reliable instrument, the following changes are needed: One, inclusion of a standardized patient assessment process, which gets at the heart of what Sandra was talking about; two, development of a statistically valid sampling methodology; three, proper training for surveyors; and four, stronger focus on resident rights.

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[16] "Please see appendix 4, page 818, for documents pertaining to *Smith* v. *Bowen*."

There is a critical need for adequate funds to inspect nursing homes. I would comment both with respect to Senator Pryor's and Senator Pressler's questions that there is no surprise element on survey. This is due to insufficient resources. As has been pointed out here already, the survey date can be figured out very easily by providers.

There should not only be evening surveys; there should be a Federal requirement for a percentage of evening and/or weekend surveys.

The integrity of the nursing home inspection process is dependent upon adequate funding and the surprise element. Surveyors should not be showing up at the facility when the facility is expecting them.

I am very troubled by current proposals to reduce Federal funds for nursing home inspections. To reduce budgets when a new inspection process is being implemented which requires additional resources, poses the gravest consequences for this Nation's ability to monitor the quality of health care in our nursing homes across the country. I would point out that presently less than 1 percent of the Federal Medicaid budget goes to fund nursing home inspections. The 1986 Federal Medicaid budget for the entire Nation is only $44 million.

I strongly favor the National Academy of Sciences IOM Report that recommends 100 percent Federal funding for Federal nursing home inspections.[17] I would add respectfully that a dollar is just as important to you at the Federal Government level as it is at the State level. I understand that a $100 million item is not even itemized in the Federal budget. Can you imagine how much we could strengthen this Nation's nursing home system with $95 million? It would be incredible.

We need some key enforcement sanctions. Federal Medicaid Program requirements should include an effective array of enforcement sanctions. It is not in the best interest of nursing home residents that the only Federal sanction is cancellation of the Medicaid contract. I have serious reservations about withholding the payments. A contract cancellation forces the relocation of Medicaid residents, and it punishes the wrong party.

Sanctions will assist the State and Federal Governments in assuring quality of care for nursing home residents. Three sanctions are needed:

First, a ban on admissions. When resident care is substandard, a ban on admissions is the most valuable enforcement tool that we can have. New admissions, as Sandra here could tell you, require a substantial amount of work. The ban protects the health and safety of residents by forcing the facility to target resources toward correction of deficiencies. Further, a ban on admissions creates a financial incentive and puts public pressure on the nursing home to achieve and maintain compliance with health and safety standards.

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[17] See p. 139 for the position statement of the AHFLCD on the IOM report.

Second, civil fines. They are an enforcement option badly needed by program administrators. They have proven to be a valuable enforcement tool in numerous States. I hope someone will ask me about substandard homes, because I have a few suggestions to make.

Third, receivership. Receivership is a temporary action to protect the health and safety of residents when a nursing home cannot meet the care needs of its residents. Receivership permits the State to act as a manager of the home and as a trustee until the quality of care is restored.

What about the new Federal termination procedures? I want to commend HHS for their work to improve Federal termination procedures. However, the procedures do not provide appropriate responses for receivership or ownership changes. The problem is that even if the nursing home provider is the source of the trouble, and a new, credible owner takes over, the new procedures still force the relocation of all Medicaid recipients. Isn't that a little like throwing the baby out with the bathwater? I believe it is.

HHS further informs us that the new procedures only apply to Medicare. Yet they recommended them for use by the States in administering the Medicaid Program. This ambiguity has created problems for the States. No Federal regulations have been promulgated to apply these termination procedures to Medicaid. The failure of HHS to deal specifically with Medicaid certainly seems inconsistent with the court's ruling in the *Smith* case. Moreover, they are not consistent with Medicaid requirements. For example, they do not provide for a timely—and I emphasize timely—informal conference with the nursing home provider prior to termination, which is currently a requirement under the Code of Federal Regulations.

With respect to the continuing problem of Medicaid discrimination against Medicaid recipients, I applaud the work of Senator Heinz and this committee to eliminate discrimination against Medicaid recipients. Your work is deeply appreciated. Clearly, our most frail and defenseless elderly citizens should not have to fight Medicaid discrimination in addition to the aging process.

Washington State has already recognized this by enacting legislation prohibiting discrimination against Medicaid recipients. The lack of antidiscrimination enforcement currently undermines the basic entitlement of Medicaid recipients to receive nursing home care. My written submitted testimony lists examples of discrimination which should be unlawful for any nursing home with a Medicaid contract.

My last point—and I want to stress it, because to me it is critically important—is nurse aide training. The importance of nurse aide training cannot be overstated.

Nursing assistants, often referred to as nurse aides, deliver more than 80 percent of resident care in nursing homes. The Federal Government should mandate national training standards for nursing assistants. It is not that expensive.

In closing, I want to thank you again for this opportunity to contribute to the improvement of quality of life and quality of care for nursing home residents.

[The prepared statement of Mr. Thompson follows:]

THE UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
SENATOR JOHN HEINZ, CHAIRMAN

TESTIMONY BY CONRAD THOMPSON, DIRECTOR
BUREAU OF NURSING HOME AFFAIRS
WASHINGTON STATE

MAY 21, 1986

MR. CHAIRMAN AND COMMITTEE MEMBERS:

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY WITH RESPECT TO NURSING HOME RESIDENTS. MY NAME IS CONRAD THOMPSON. I SERVE AS DIRECTOR OF THE BUREAU OF NURSING HOME AFFAIRS FOR THE STATE OF WASHINGTON AND HAVE FOR THE PAST SEVEN YEARS. THE BUREAU IS RESPONSIBLE FOR STATE LICENSURE AND FEDERAL CERTIFICATION OF NURSING HOMES. IN ADDITION, THE BUREAU IS RESPONSIBLE FOR FEDERAL UTILIZATION REVIEW AND INSPECTION OF CARE REQUIREMENTS AND ESTABLISHES MEDICAID PAYMENT RATES FOR NURSING HOME CARE. THE STATE HAS ABOUT THREE HUNDRED NURSING HOMES, WITH A TOTAL OF 27,000 BEDS. SIXTY PERCENT OF THESE BEDS ARE OCCUPIED BY MEDICAID RECIPIENTS.

I WILL DISCUSS THE FOLLOWING TOPICS:

- NEW FEDERAL NURSING HOME INSPECTION PROCESS
- NEED FOR ADEQUATE FUNDS TO INSPECT NURSING HOMES
- NEED FOR THREE KEY ENFORCEMENT SANCTIONS
- NEW FEDERAL NURSING HOME TERMINATION PROCEDURES
- CONTINUING PROBLEM OF DISCRIMINATION AGAINST MEDICAID RECIPIENTS
- NATIONAL TRAINING STANDARDS FOR NURSING ASSISTANTS
- NATIONAL ACADEMY OF SCIENCES' REPORT ON NURSING HOMES
- EXCEEDINGLY HARSH AUDIT PENALTIES

NEW FEDERAL NURSING HOME INSPECTION PROCESS

IN 1984, THE UNITED STATES COURT OF APPEALS, IN A LANDMARK CASE, FOUND FOR THE PLAINTIFFS, SMITH AND THE STATE OF COLORADO, VS. HECKLER, THEN SECRETARY FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS). THE COURT RULED THAT THE FEDERAL NURSING HOME ENFORCEMENT SYSTEM MUST ENSURE THAT MEDICAID RECIPIENTS ARE RECEIVING QUALITY CARE AND THAT THE SECRETARY OF HHS HAS A DUTY WITH RESPECT TO QUALITY CARE.

THE COURT DETERMINED THAT THE PRESENT FEDERAL SURVEY PROCESS DOES NOT JUDGE QUALITY OF RESIDENT CARE. THE COURT'S RULING AND JOHN HOLLAND, COUNSEL FOR THE PLAINTIFFS, CREATED A TREMENDOUS OPPORTUNITY TO IMPROVE AND ASSURE QUALITY CARE FOR NURSING HOME RESIDENTS.

IN RESPONSE TO THE COURT'S RULING, HHS DEVELOPED THE NEW FEDERAL NURSING HOME INSPECTION PROCESS, FORMERLY CALLED PACS. I UNDERSTAND THE IMPLEMENTATION DATE HAS NOW BEEN MOVED UP TO JULY 1, 1986. THE NEW PROCESS FOCUSES ON THE QUALITY OF CARE PROVIDED RATHER THAN THE FACILITY'S COMPLIANCE WITH PAPER REQUIREMENTS. IN THIS RESPECT, IT IS A SIGNIFICANT STEP FORWARD. HOWEVER, THE NEW PROCESS HAS FUNDAMENTAL FLAWS. TO MAKE IT A VALID AND RELIABLE PROCESS, THE FOLLOWING CHANGES ARE NEEDED:

- INCLUSION OF A STANDARDIZED PATIENT ASSESSMENT PROCESS,
- DEVELOPMENT OF A STATISTICALLY VALID SAMPLING METHODOLOGY,

- PROPER TRAINING FOR SURVEYORS, AND
- STRONGER FOCUS ON RESIDENT RIGHTS, THE PHYSICAL PLANT ENVIRONMENT AND ADMINISTRATIVE RESPONSIBILITY.

NEED FOR ADEQUATE FUNDS TO INSPECT NURSING HOMES

THE INTEGRITY OF THE NURSING HOME INSPECTION PROCESS IS DEPENDENT UPON ADEQUATE FUNDING AND THE SURPRISE ELEMENT. SURVEYORS SHOULD NOT BE SHOWING UP WHEN THE FACILITY IS EXPECTING THEM. I AM TROUBLED BY CURRENT PROPOSALS TO REDUCE FEDERAL FUNDS FOR NURSING HOME INSPECTIONS. TO REDUCE BUDGETS WHEN A NEW INSPECTION PROCESS IS BEING IMPLEMENTED, WHICH REQUIRES ADDITIONAL RESOURCES, POSES THE GRAVEST CONSEQUENCES FOR THE NATION'S ABILITY TO MONITOR THE QUALITY OF HEALTH CARE.

PRESENTLY, LESS THAN ONE PERCENT OF THE FEDERAL MEDICAID BUDGET GOES TO FUND NURSING HOME INSPECTIONS. THE 1986 FEDERAL MEDICAID BUDGET FOR THE ENTIRE NATION IS ONLY FORTY-FOUR MILLION DOLLARS. I AM IN FAVOR OF THE RECOMMENDATION BY THE NATIONAL ACADEMY OF SCIENCES, WHICH CALLS FOR REINSTITUTING ONE HUNDRED PERCENT FEDERAL FUNDING FOR NURSING HOME CERTIFICATION INSPECTIONS.

NEED FOR THREE KEY ENFORCEMENT SANCTIONS

FEDERAL MEDICAID PROGRAM REQUIREMENTS SHOULD INCLUDE AN EFFECTIVE ARRAY OF ENFORCEMENT SANCTIONS. IT IS NOT IN THE BEST INTERESTS OF NURSING HOME RESIDENTS THAT THE ONLY FEDERAL SANCTION IS CANCELLATION OF THE MEDICAID CONTRACT. A CONTRACT CANCELLATION FORCES THE RELOCATION OF MEDICAID RESIDENTS, PUNISHING THE WRONG PARTY. SANCTIONS WILL ASSIST THE STATE AND FEDERAL GOVERNMENT IN ASSURING QUALITY CARE FOR NURSING HOME RESIDENTS. SANCTIONS NEEDED ARE:

1. A BAN ON ADMISSIONS. WHEN RESIDENT CARE IS SUBSTANDARD, A BAN ON ADMISSIONS IS A VALUABLE ENFORCEMENT TOOL. NEW ADMISSIONS REQUIRE A SUBSTANTIAL AMOUNT OF WORK. THE BAN PROTECTS THE HEALTH AND SAFETY OF RESIDENTS BY FORCING THE FACILITY TO TARGET RESOURCES TOWARD CORRECTION OF DEFICIENCIES. FURTHER, A BAN ON ADMISSIONS CREATES A FINANCIAL INCENTIVE AND PUTS PUBLIC PRESSURE ON THE NURSING HOME TO ACHIEVE AND MAINTAIN COMPLIANCE WITH HEALTH AND SAFETY STANDARDS.

2. CIVIL FINES. CIVIL FINES ARE AN IMPORTANT ENFORCEMENT OPTION TO PROGRAM ADMINISTRATORS. THEY HAVE PROVEN TO BE A VALUABLE ENFORCEMENT TOOL IN NUMEROUS STATES.

3. RECEIVERSHIP. RECEIVERSHIP IS A TEMPORARY ACTION TO PROTECT THE HEALTH AND SAFETY OF RESIDENTS. WHEN A NURSING HOME CANNOT MEET THE CARE NEEDS OF ITS RESIDENTS, RECEIVERSHIP PERMITS THE STATE TO ACT AS A MANAGER OF THE HOME AND AS A TRUSTEE ON BEHALF OF RESIDENTS UNTIL QUALITY OF CARE IS RESTORED.

NEW FEDERAL NURSING HOME TERMINATION PROCEDURES

HHS SHOULD BE COMMENDED FOR ITS WORK TO IMPROVE FEDERAL TERMINATION PROCEDURES. HOWEVER, THE PROCEDURES DO NOT PROVIDE FOR APPROPRIATE RESPONSES TO RECEIVERSHIP ACTIONS OR OWNERSHIP CHANGES. THE PROBLEM IS THAT, EVEN IF THE NURSING HOME PROVIDER IS THE SOURCE OF THE TROUBLE AND A NEW CREDIBLE OWNER TAKES OVER, THE NEW PROCEDURES STILL FORCE THE RELOCATION OF ALL MEDICAID RECIPIENTS. ISN'T THIS THROWING THE BABY OUT WITH THE BATH WATER?

HHS INFORMS US THE NEW PROCEDURES ONLY APPLY TO MEDICARE. YET, THEY "RECOMMENDED" THE STATES USE THEM IN ADMINISTERING THE MEDICAID PROGRAM. THIS AMBIGUITY CREATES PROBLEMS FOR THE STATES. NO FEDERAL REGULATIONS HAVE BEEN PROMULGATED TO APPLY THESE TERMINATION PROCEDURES TO MEDICAID. THE FAILURE OF HHS TO DEAL SPECIFICALLY WITH MEDICAID SEEMS INCONSISTENT WITH THE COURT'S RULING IN THE SMITH CASE. MOREOVER, THEY ARE NOT CON-

SISTENT WITH MEDICAID REQUIREMENTS. FOR EXAMPLE, THEY DO NOT PROVIDE FOR AN INFORMAL CONFERENCE WITH THE NURSING HOME PROVIDER PRIOR TO TERMINATION, WHICH IS A CLEAR REQUIREMENT UNDER THE CODE OF FEDERAL REGULATIONS.

CONTINUING PROBLEM OF DISCRIMINATION AGAINST MEDICAID RECIPIENTS

I APPLAUD THE WORK OF SENATOR HEINZ AND THIS COMMITTEE TO ELIMINATE DISCRIMINATION AGAINST MEDICAID RECIPIENTS. YOUR WORK IS DEEPLY APPRECIATED. CLEARLY, OUR MOST FRAIL AND DEFENSELESS CITIZENS SHOULD NOT HAVE TO FIGHT MEDICAID DISCRIMINATION, IN ADDITION TO THE AGING PROCESS. THE STATE OF WASHINGTON HAS ALREADY RECOGNIZED THIS BY ENACTING LEGISLATION PROHIBITING DISCRIMINATION AGAINST MEDICAID RECIPIENTS. IT INCLUDES PROVISIONS FOR CIVIL FINES AND THE APPLICATION OF STATE CONSUMER PROTECTION LAWS.

THE LACK OF FEDERAL ANTI-DISCRIMINATION RULES UNDERMINES THE BASIC ENTITLEMENT OF MEDICAID RECIPIENTS TO RECEIVE NECESSARY NURSING HOME CARE. IT SHOULD BE UNLAWFUL FOR ANY NURSING HOME WITH A MEDICAID CONTRACT TO:

A) REQUIRE, AS A CONDITION OF ADMISSION, ASSURANCE FROM THE RESIDENT OR ANY OTHER PERSON THAT THE RESIDENT IS NOT ELIGIBLE FOR OR WILL NOT APPLY FOR MEDICAID;

B) DENY OR DELAY ADMISSION OR READMISSION OF A PERSON TO A NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT;

C) TRANSFER A RESIDENT WITHIN THE NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT;

D) TRANSFER A RESIDENT TO ANOTHER NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT;

E) DISCHARGE OR TRANSFER A RESIDENT FROM A NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT; OR

F) CHARGE ANY AMOUNTS IN EXCESS OF THE MEDICAID RATE FROM THE DATE OF ELIGIBILITY.

NATIONAL TRAINING STANDARDS FOR NURSING ASSISTANTS

THE IMPORTANCE OF NURSE AIDE TRAINING TO QUALITY RESIDENT CARE CANNOT BE OVERSTATED. NURSING ASSISTANTS DELIVER MORE THAN EIGHTY PERCENT OF RESIDENT CARE. THE FEDERAL GOVERNMENT SHOULD MANDATE NATIONAL TRAINING STANDARDS FOR NURSING ASSISTANTS. IT IS NOT EXPENSIVE. IN OUR STATE, THE COST OF TRAINING A NURSING ASSISTANT IS ABOUT ONE HUNDRED DOLLARS, OF WHICH FIFTY DOLLARS IS PAID BY THE FEDERAL GOVERNMENT. WHEN A SIGNIFICANT NUMBER OF NURSING ASSISTANTS ARE TRAINED, THE COST SUBSTANTIALLY

DIMINISHES. THE QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS WILL SUBSTANTIALLY IMPROVE AS A RESULT OF TRAINING REQUIREMENTS.

NATIONAL ACADEMY OF SCIENCES' REPORT ON NURSING HOMES

THE REPORT, ENTITLED IMPROVING THE QUALITY OF CARE IN NURSING HOMES, RECOMMENDS STRENGTHENING THE NURSING HOME REGULATORY SYSTEM. CONGRESS ASKED HHS TO CONTRACT THE STUDY, FOLLOWING THE PUBLIC OUTCRY AFTER HHS MOVED TO REDUCE REGULATION OF THE NURSING HOME INDUSTRY IN 1982.

MY COLLEAGUES ACROSS THE NATION AND I CONCUR THAT DEREGULATION OF THE NURSING HOME INDUSTRY IS ILL-ADVISED AND THAT THE CURRENT FEDERAL REGULATORY SYSTEM IS DEFICIENT. NEEDED IS A REGULATORY SYSTEM THAT IS OUTCOME-ORIENTED AND RECOGNIZES THERE MAY BE MORE THAN ONE APPROACH TO ACHIEVING DESIRED RESULTS, BOTH IN THE PROVISION OF PATIENT CARE AND THE ADMINISTRATION OF STATE REGULATORY PROGRAMS. OF COURSE, SOME UNIFORMITY IN APPROACH IS REQUIRED AND DESIRABLE. THE ISSUE IS ONE OF REASONABLE BALANCE.

THE ACADEMY'S REPORT RESULTS FROM THE FIRST COMPREHENSIVE LOOK AT FEDERAL NURSING HOME REQUIREMENTS IN OVER A DECADE. IT PROVIDES A NEEDED FRAMEWORK FOR IMPROVING THE QUALITY OF LIFE FOR NURSING HOME RESIDENTS. IT

IS IMPERATIVE HHS ADOPT A SYSTEMATIC AND COOPERATIVE APPROACH TO IMPLEMENTING FEDERAL PROGRAM CHANGES IN THE FEDERAL MEDICAID PROGRAM. HHS MUST INVOLVE CONSUMER, PROVIDER AND STATE REPRESENTATIVES IN PLANNING, DEVELOPING AND IMPLEMENTING PROGRAM CHANGES. WE ARE THE CHANGE AGENTS WHO MUST FINALLY IMPLEMENT CHANGES. STRATEGIC PLANNING WILL MAXIMIZE PROGRAM AND COST EFFECTIVENESS.

EXCEEDINGLY HARSH AUDIT PENALTIES

WASHINGTON AND OTHER STATES ARE EXPERIENCING AN INCREASING NUMBER OF SEVERE FINANCIAL PENALTIES FROM FEDERAL NURSING HOME UTILIZATION CONTROL AUDITS. THE AUDIT CRITERIA ARE SERIOUSLY FLAWED IN THAT THEY SIMPLY MEASURE WHETHER THERE IS A ONE HUNDRED PERCENT COMPLIANCE WITH PAPER AND CALENDAR DATE REQUIREMENTS. IF A SINGLE PATIENT IN A FACILITY IS NOT REVIEWED BY A SPECIFIC DATE OR A PAPER REQUIREMENT NOT MET, THEN THE ENTIRE FACILITY IS OUT OF COMPLIANCE.

THE FEDERAL GOVERNMENT THEN LEVIES A SEVERE FINANCIAL PENALTY AGAINST THE STATE. THE ENTIRE MEDICAID POPULATION IS USED TO COMPUTE THE PENALTY. THIS IS TRUE EVEN IF THE CARE AND SERVICES BEING PROVIDED ARE SUPERIOR. THE PENALTIES ARE SO DRACONIAN THE AUDITS HAVE COME TO BE VIEWED AS A REVENUE TRAP AGAINST THE STATES. THESE PENALTIES TRANS-

LATE INTO LESS DOLLARS AVAILABLE TO MEET THE LEGITIMATE NEEDS OF MEDICAID RECIPIENTS. ATTACHED IS PROPOSED LANGUAGE WHICH ESTABLISHES A REASONABLE PENALTY PROVISION.

THANK YOU FOR THIS OPPORTUNITY TO CONTRIBUTE TO IMPROVING THE QUALITY OF CARE AND THE QUALITY OF LIFE FOR NURSING HOME RESIDENTS.

ATTACHMENTS:

(1) PROPOSED AUDIT PENALTY PROVISION

(2) LETTER TO THE HEALTH CARE FINANCING ADMINISTRATION FROM THE ASSOCIATION OF HEALTH FACILITY LICENSURE AND CERTIFICATION DIRECTORS REGARDING THE NEW FEDERAL NURSING HOME INSPECTION PROCESS

(3) MEMO TO STATE LICENSURE AND CERTIFICATION DIRECTORS FROM THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Section 1903 (g) (5) Social Security Act

(5) In the case of a state's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in calendar quarter, the per centum amount of the reduction of the state's federal medical assistance percentage for that type of services under paragraph (1) ~~is equal to~~ shall be calculated as follows: 33 1/3 per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the state plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter. Where the amount of reduction thus calculated is 5 per centum or less, no reduction shall be made. Where the calculated reduction exceeds 5 per centum, a reasonableness factor of .05 shall be subtracted from the product.

cc: [illegible]
Sharon M.
Gartien A.
Sid Okan
Denny M.
Lou Elinger
Chuck Hawley
John Stily
return (2)

Association of Health Facility Licensure and Certification Directors

AHFLCD

December 4, 1985

Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-119-P, P. O. Box 26676
Baltimore, Maryland 21207

Dear Administrator:

The Association of Health Facilities Licensure and Certification Directors appreciates the opportunity to comment on the proposed rule relating to Medicare and Medicaid Programs; Long-Term Care Survey, which was published in the Federal Register on October 31, 1985.

As the managers in the State Survey Agencies to which devolves the responsibility for implementation of health facility survey and certification programs, AHFLCD has within its ranks virtually all of the collective expertise and experience in application of those systems at the State level. We are confident, therefore, that input from this group will be carefully considered.

We applaud and support the concept of focusing on resident needs and describing the degree to which those needs are met by the facility as a function of compliance with certification requirements. As known to us on November 15, 1985, the proposed outcome-oriented PaCS survey instrument does represent the initiation of desirable changes in the current survey process. However, as a result of considerable discussion during the November Annual Meeting, it was unanimously determined that AHFLCD support of the PaCS system as currently proposed, is contingent upon its revision to include the following elements:

(1) that the final form of any changes take into consideration recommendations forthcoming from the Institute of Medicine and other academic, contracted, or pilot project studies;

(2) that the Health Care Financing Administration publish survey forms, interpretive guidelines and general instructions and make same available for general comment as part of the Notice of Proposed Rule Making or other process prior to implementation;

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SURVEY PROGRAM

(3) that the Health Care Financing Administration develop and announce detailed training plans for administrative and survey staff that will promote excellent and consistent implementation and administration of the revised process;

(4) that the proposed survey process include a sampling methodology and comprehensive standardized patient assessment procedure that will merit a high degree of confidence in survey findings and will successfully withstand critical professional and legal scrutiny; and

(5) that any proposed changes in the current survey system respect state-to-state variations existent between survey and certification activities and Inspection of Care programs and that appropriate funding is assured in the face of such changes.

The opportunity to modify the current system is welcomed and appreciated to the extent that we can participate as partners in constructive dialogue and advocate for changes that will provide for a process that will enhance our ability to measure service delivery to beneficiaries. It is our opinion that such an outcome can best be achieved by convening a work group comprised of knowledgeable consumers, providers, and regulators charged with the responsibility to discuss concerns and to develop implementation strategies commensurate with the human and financial commitments required for an undertaking of this magnitude.

Sincerely,

John J. Jarrell

John J. Jarrell,
President
c/o Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305

cc: Fay Iudicello
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 3208, New Executive Office Building
Washington, D.C. 20503

bc: AHFLCD Membership
Sharon Harris
Thomas Vernon, M. D.
Elma Holder

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder, Executive Director
Freida Gorrecht, President

1424 16th Street, N.W.
Suite L2
Washington, DC 20036
202-797-0657

April 16, 1986

TO: State Licensure and Certification Directors
FROM: Elma Holder and Barbara Frank, NCCNHR
RE: New Long Term Care Survey Process and Institute of Medicine Report

New Long Term Care Survey Process

We sent the enclosed Statement of Concerns, with 20 co-signers, to Sharon Harris on April 9, 1986. As indicated in our comments of December, 1986 in response to the NPRM, we support implementation of the new survey process, however we continue to be concerned about the implementation process. Our major concerns regard: (1) sufficient time for states to make the necessary adjustments for a transition to the new system; (2) adequate training for surveyors; (3) better guidelines for surveyors; (4) better cooperation with states that have systems equal to or better than the federal process. We are also developing a letter, which we will share with you, addressing specific concerns about training, based on our observation of the first HCFA training on the new survey process, in Baltimore in February.

Our goal is to support implementation of the new survey process in the most constructive manner possible in order to put in place the best possible protections for nursing home residents. We need your assistance to provide comprehensive information to those interested in this goal. Please answer the enclosed questionnaire to the best of your ability and return it to us by May 9, so we can present this information to members of Congress, concerned national organizations and others during the public discussions about nursing home regulation this spring and summer. This survey has been reviewed by Jerry Jarrell.

We realize this is a short time frame for completion of our request. If you need to call with information and send further details later, you can reach us at (202) 797-0657 We recognize that this survey will take time and effort. Thank you for your assistance. The results will be shared with each state agency later this spring.

Finally we take this opportunity to encourage you to work with your state and local ombudsman programs, citizens groups and residents councils, especially during this implementation period. Many of these groups are anxious to hear how you plan to implement the new survey process and anxious to assist in community education, preparation of residents, and surveyor training, particularly in the areas of communication skills and residents rights. Concerns of residents about retaliation for their participation in the survey would be useful to discuss with these groups. They are interested in knowing about your plans and concerns, and assisting wherever possible.

Institute of Medicine Report

The report of the Institute of Medicine's Study Committee on Nursing Home Regulation is now available for $24.95 from National Academy Press, 2101 Constitution Ave., N.W. Washington, D.C., 20014; (202) 334-3313. The report, entitled Improving the Quality of Care in Nursing Homes, lays the groundwork for significant improvements in the nursing home regulatory system. NCCNHR convened a meeting on April 2 with national organizations, (Jerry Jarrell attended) to begin review of the report. Organizations agreed to work in cooperation on implementation of the recommendations. We'll continue to communicate with you as this progresses and look forward to hearing more of your comments.

Thank you again for your assistance. Best wishes!

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder Executive Director
Frieda Gorrecht President

1424 16th Street, N.W.
Suite L2
Washington, DC 20036
202-797-0657

April 9, 1986

STATEMENT OF CONCERNS

RE: HCFA'S NEW LONG TERM CARE SURVEY PROCESS (PaCS)

TO: Sharon Harris, Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau, HCFA

We are writing to express concerns about the implementation of the new Long Term Care Survey Process. We commend HCFA for initiating this important change in the way nursing homes are surveyed. HCFA's new long term care survey process is a positive and significant development in nursing home regulation. If implemented properly, it can tremendously strengthen HCFA's ability to monitor and assess the quality of care nursing home residents receive.

We support the process because it provides the opportunity to hear directly from residents about the quality of care and life in the homes. It focuses on the care residents actually receive rather than a home's compliance, in theory, with standards of good practice.

We recognize your agency's unprecedented efforts to share information about this new process and to solicit and incorporate recommendations for improvements. This openness has created an atmosphere for sincere discussion about how to develop a system that will best serve nursing home residents. We commend your proposed work plan which indicates continued agency activities which will contribute to an improved survey process. It is in the spirit of cooperation that we offer concerns and recommendations related to successful implementation of the new long term care survey process.

To be implemented and utilized successfully, this landmark change in nursing home regulation will require tremendous support and cooperation from federal and state regulatory agencies, nursing home providers and residents, and their representatives.

We recognize that it took a great deal of time and thought to develop this new system. Now the Health Care Financing Administration is endangering this new system with a poorly developed, unrealistic and potentially harmful implementation plan including:

(1) an unrealistic implementation schedule. States need more than two or three months to make the transition to the new procedures, format and skills required by the new system. HCFA is to be commended for postponing start-up until 30 days after publication of a Notice of Final Rule which it expects to publish by the end of April. A June start-up is much more reasonable than the planned April 1 date. However, HCFA is requiring that states totally assimilate the new process within two months of start-up.

NCCNHR is a national, non-profit membership organization, founded in 1975, to improve the long term care system and the quality of life for nursing home residents

(2) an inadequate approach to training. HCFA is training less than 10% of those who will conduct the new survey and relying on those representatives to return to their states and convey new federal policies and procedures to their co-workers. States will have to purchase training materials and duplicate training manuals in order to provide the basic orientation to their surveyors. The training itself lacks sufficient development in the area of communicating with confused (or those who appear confused) residents and with residents who manifest communication difficulties, yet such communication is essential if the new process is to work.

(3) incomplete guidelines and instructions to surveyors. Current surveyor guidelines, in draft form, are confusing and incomplete, and particularly weak in the areas of residents' rights, residents' social, emotional, and mental health needs and other quality of life areas. HCFA has acknowledged these problems and is revising the guidelines. Although surveyors must begin conducting these new surveys in June, revised guidelines for the survey process will not be completed until October 1.

(4) inadequate recognition of and cooperation with positive innovations and activities of state regulatory agencies. Many states already conduct resident focused, outcome oriented surveys and have a broader range of enforcement tools available to apply to poor homes. HCFA has told state agencies to follow the federal format and procedures without exception, or lose federal financial participation, and has expressed an unwillingness to coordinate with effective state enforcement practices.

We, the undersigned organizations, call upon the Health Care Financing Administration to give the leadership and support necessary to help this system work for the protection and welfare of nursing home residents, by taking action to:

(1) establish a reasonable phase-in period for implementation of this new process, beginning June 1 and continuing through December 31, 1986;

(2) provide direct federal training to every surveyor, to assure consistent direction and clear statements of federal policy;

(3) develop a plan for follow-up training beginning in January, 1987, and to supply training materials for every surveyor and each state agency, particularly in the areas of communication skills, residents' rights, residents' social, emotional and mental health needs, and determining what is a deficiency;

(4) maintain its commitment to revise surveyor guidelines based on the experiences and concerns of surveyors, providers, health care professionals, and consumers after all have had experience with this new process;

(5) allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and to develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers;

(6) work in partnership with regulators, providers and consumers to educate the public and maximize public participation in and understanding of the process;

(7) establish a task force of regulators, providers, health professionals, and consumers to monitor implementation and evolution of this new system and assist in development of training materials, surveyor guidelines and public education activities.

This new process is an evolutionary one. If implemented correctly, it can contribute to the many reforms in the system that are necessary reforms that are addressed in the March, 1986 Institute of Medicine report.

Changes in the way surveyors conduct surveys will require changes in approach, in attitudes, in skills, and in experience. These changes are much too important to be lost by shortcuts during this critical implementation period.

Co-signers of the Statement of Concerns

American Association of Homes for the Aging
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Health Care Association
American Nurses Association
American Occupational Therapy Association
American Psychological Association
American Society of Consultant Pharmacists
National Association of Area Agencies on Aging
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Association of State Units on Aging
National Citizens' Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Senior Citizens
National Support Center for Families of the Aging
Service Employees International Union
Unitarian Universalist Association

MEDICAID UTILIZATION CONTROL PENALTIES LEVIED BY HCFA TO THE REPRESENTATIVE STATES OF THE SENATE SPECIAL COMMITTEE ON AGING

DATA COMPILED FROM HCFA'S BUREAU OF QUALITY CONTROL
"MEDICAID UTILIZATION CONTROL PENALTIES"
JANUARY 1977 THROUGH DECEMBER 1984

STATE	PERIOD	LEVEL OF CARE	TOTAL AMOUNT OF PENALTY
ARKANSAS	1/80-3/80	SNF	$12,251.34
ARKANSAS	7/83-9/83	SNF	$114,662.63 *
ARKANSAS	4/83-6/83	SNF/ICF	$157,986.78
ARKANSAS	10/84-12/84	MH	$74.34 *
ARKANSAS	1/84-9/84	ICF,ICF/MR,MH	$363,421.02 *
CALIFORNIA	10/83-12/83	ICF	$244,764.49 *
CONNECTICUT	7/83-9/83	SNF	$104,385.55
FLORIDA	1/84-9/84	SNF,ICF,ICF/MR	$387,490.92 *
FLORIDA	4/82-6/82	SNF/ICF	$125,536.22
LOUISIANA	1/84-9/84	ICF,ICF/MR	$462,429.75 *
LOUISIANA	10/82-6/83	ICF	$840,232.82
LOUISIANA	7/83-9/83	ICF,ICF/MR	$31,711.38
MAINE	7/82-9/82	ICF	$87,666.64
NEW JERSEY	7/83-9/83	SNF	$3,587.95
NORTH DAKOTA	7/78-9/78	SNF	$55,090.00
OHIO	1/84-9/84	SNF,ICF,ICF/MR	$269,837.17 *
OHIO	7/78-9/78	SNF	$123,807.00
OHIO	4/79-6/79	MH	$438,970.71
OHIO	10/80-6/81	ICF/MR	$1,194,130.38
OHIO	4/83-6/83	ICF/MR	$11,567.82
OKLAHOMA	10/83-12/83	ICF	$232,567.49 *
OKLAHOMA	10/82-6/83	ICF	$165,850.97
OKLAHOMA	7/80-9/80	ICF	$181,991.68
PENNSYLVANIA	1/84-9/84	SNF,ICF,ICF/MR	$716,112.00 *
PENNSYLVANIA	4/82-6/82	ICF/SNF	$488,348.16
SOUTH DAKOTA	1/80-3/80	SNF	$8,921.14
SOUTH DAKOTA	1/84-9/84	ICF,ICF/MR	$36,537.00 *
SOUTH DAKOTA	4/82-6/82	SNF	$4,049.55
VIRGINIA	10/83-12/83	ICF	$292,732.28 *
VIRGINIA	1/84-9/84	SNF,ICF,ICF/MR,IMD	$315,526.84 *
VIRGINIA	1/80-3/80	SNF	$19,022.14
WASHINGTON	7/80-9/80	ICF,ICF/MR	$102,163.09
WASHINGTON	1/84-9/84	SNF,ICF,ICF/MR	$334,400.39 *
WASHINGTON	7/82-9/82	ICF	$15,016.79
WASHINGTON	4/82-6/82	SNF	$172,506.60
	TOTALS		$8,115,371.01

* PENDING REVIEW BY DHHS' GRANT APPEALS BOARD

Association of Health Facility Licensure and Certification Directors

May 21, 1986

Dear Reader:

The Association of Health Facility Licensure and Certification Directors supports the Institute of Medicine (IOM) report released by the National Academy of Sciences. The report, pertaining to nursing homes, is the first comprehensive review of federal nursing home requirements in over a decade. The report's recommendations provide a needed framework for improving the quality of life and care for nursing home residents. It is vitally important that a systematic approach be adopted for implementing program changes. Stategic planning will maximize both program and cost effectiveness.

The U.S. Department of Health and Human Services is the entity responsible for planning, developing and coordinating implementation of federal program changes. It is essential that consumers, providers and state regulators be involved in these efforts. We are the change agents who must finally implement program changes. Nursing home residents are the ultimate benefactors of a collective effort.

The attached statement is the Association's response to the recommendations made in the IOM report. If you desire further information or if we may be of assistance please write or call Conrad Thompson, Vice-President or me. We may be contacted at:

John J. Jarrell, Director
Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305
(304) 348-0050

Conrad Thompson, Director
Bureau of Nursing Home Affairs
Department of Social & Health Services
623 8th Avenue, Southeast
Olympia, Washington 98504
(206) 753-5840

Sincerely,

John Jarrell

John J. Jarrell
President

attachment

monitoring the health care of a nation

Association of Health Facility Licensure and Certification Directors

Association Statement on the Report, *Improving the Quality of Care in Nursing Homes* by the National Academy of Sciences' Instititute of Medicine Committee on Nursing Home Regulation

John J. Jarrell, President
AHFLCD

May 21, 1986

monitoring the health care of a nation

AHFLCD Issues Committee Members:
- Ron Barth--Illinois
- Juan Lopez--New Mexico
- Brant Van Meter--Oklahoma
- Dana Petrowsky--Iowa
- Lou Remily--Wisconsin
- George Warner--New York
- Conrad Thompson--Washington, Chairperson

Association of Health Facility Licensure and Certification Directors

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BACKGROUND

The National Academy of Sciences recently released a report recommending regulatory reforms to federal nursing home requirements. The report, entitled "Improving the Quality of Care in Nursing Homes," was conducted by the Committee on Nursing Home Regulation which was appointed by the National Academy of Sciences' Institute of Medicine. The federal Department of Health and Human Services (HHS) was asked by Congress to contract for the study, following public outcry when HHS moved to reduce regulations for the nursing home industry in 1982. The report recommends strengthening the nursing home regulatory system.

POSITION STATEMENT

The Association of Health Facility Licensure and Certification Directors supports the thrust of the report. Deregulation of the nursing home industry is ill advised. A regulatory system that is patient outcome oriented and dynamic in nature is needed; one which emphasizes quality of care and quality of life for nursing home residents.

QUALITY CARE

The current federal conditions of participation relating to care focuses on disciplinary requirements; i.e. nursing, social service, and dietary conditions. The IOM Committee recommends reorienting the federal standards to concentrate on actual care being provided. Residents should be involved in determining their care needs as much as possible. A new condition on quality of care should identify desirable resident outcomes of care, pertaining to functional status, physical well-being and safety, emotional well-being, social involvement and participation, cognitive functioning and resident satisfaction. Specifying desired outcomes is important because it focuses on the purpose of nursing home care.

QUALITY OF LIFE

Unlike other medical care settings, the nursing home is a place of residence. Both the IOM report and a study of quality of life as viewed by nursing home residents emphasize that quality of life is of major importance to residents, in addition to quality care. A report by the National Citizens Coalition for Nursing Home Reform, entitled A Consumer Perspective on Quality Care: The Residents' Point of View, best addresses quality of life. Residents indicate a number of factors which contribute to the quality of life include:

- a supportive, comfortable, homelike environment
- a choice of surroundings, schedules, health care, menus, and activities
- treatment with dignity and respect
- opportunities to interact with family members and community members inside and outside the nursing home, and
- well-trained qualified workers.

The federal regulations currently do not address quality of life. A new condition of participation concerning quality of life should be added to the certification requirements.

RESIDENT ASSESSMENT

A standardized resident assessment system is essential to evaluate the care needs of each resident upon admission in order to develop an individual plan of care. Periodic reassessments are necessary to monitor changes in the resident's health and to modify the care plan. A resident assessment system contributes to:

- o determining case-mix and patient outcomes
- o determinining the need for care and services required through utilization review
- o establishing Medicaid reimbursement (for states which utilize case-mix as a factor in Medicaid payment)
- o evaluating Certificate of Need and planning
- o determining staffing needs
- o estimating future costs of care, and
- o determining effectiveness of nursing home management of care delivery.

Standard resident assessment data should be part of a database for use by the state and federal governments.

To effectively implement resident assessment, the necessary data and methods of collection must be clearly defined. Residents should be involved in the assessment process and adequate training must be provided to qualified staff. Assessing residents functional capacity and care needs requires the skills of several health care professionals; including nurses, physicians, therapists and social workers. The validity of a nursing home's resident assessments requires careful monitoring by qualified, professional staff not associated with the home. HHS should initiate training programs for facility and state staffs. This will ensure that resident assessment data is collected and monitored in a consistent manner. The state regulatory agency or their designee should audit the home's resident assessments.

REMOVAL OF ICF/SNF CERTIFICATION DISTINCTION

A single set of certification standards for ICF/SNF nursing homes is advisable. The care needs of residents in these settings now cannot be clearly distinguished. Separate sets of federal certification criteria serve as a barrier to relocating patients. Intermediate Care Facilities are reluctant to transfer a resident needing the nursing care provided by an SNF because relocation could be traumatic to the resident. A single criteria should better assure the health and safety of all residents. Additional licensed nursing staff should be required to provide increased supervision and monitoring of nurse aides, resident assessments, and directing and supervising care services.

RESIDENT'S RIGHTS

The current federal standard pertaining to resident rights is unclear and lacks enforcement capability. The standard needs clarification. A new condition of participation is warranted to ensure a resident's right to receive equitable treatment, necessary information, reasonable choices and should require that residents be:

- informed of legal rights
- able to contact the state survey office
- permitted to participate in the development of facility policies and personal care plans
- assured access to survey reports and plans of correction
- permitted to inspect their medical and social records
- given prior notice of transfer, discharge, or expiration of bed hold
- given the opportunity to participate in resident councils, advisory committees and family councils, and
- given the opportunity to participate in social, religious, and political activities, and have private visits with persons of choice.

Resident rights are important and deserve to be addressed in a separate condition. The new condition should also recognize the rights of the cognitively impaired and by requiring that residents rights devolve to the patient's guardian or responsible party.

ADMINISTRATION

The IOM report advocates incorporating seven existing conditions into one condition entitled "Administration." The existing conditions of governing body and management, utilization review, transfer agreements, disaster preparedness, medical direction, laboratory and radiological services, and medical records would be combined together as standards under one condition. The condition should also mandate nurse aide training, prohibit discrimination, allow resident particicipation in facility decision-making, and assure access by ombudsmen and consumer advocates to the nursing home.

Nurse aide training should be added as a standard to the administration condition to require that all nurse aides complete an approved training program. Training of nurse aides is critically important to quality care. Nearly 80% of the care delivered to nursing home residents is provided by nurse aides. Given the predominance and importance of their role, effective on-going training programs are essential to quality resident care.

A new standard prohibiting discrimination needs to be part of the condition of administration. Because there are more people seeking admissions to nursing homes than there are beds available, nursing homes may select residents requiring minimal care, rather than heavy care residents. Providing care for patients requiring lighter care needs is less costly. There is a financial incentive to admit a private pay resident rather than a Medicaid patient and to evict residents once they have exhausted their private funds. Discrimination must not be permitted to occur in facilities that participate in government programs. This nation's most frail, vulnerable citizens should not have to fight discrimination in addition to the aging process.

A standard requiring nursing homes to permit access by local area ombudsmen and consumer advocates should be part of the condition of administration. They are especially important to residents without visitors, family or friends. Community area advocates can serve as a resident's ally in negotiation or serve as a third party mediator. They may also serve as a conduit of consumer information to nursing home professionals and to regulatory agencies. Because of their orientation and scope of their responsibilities, the existing requirements pertaining to community area advocates should be improved.

SOCIAL SERVICES

Social services are essential in promoting quality of life and in improving social and psychological services for residents. Together, activities programs and social service programs can help residents take advantage of social, mental health, legal, educational, recreational, and spiritual affiliations in the community.

Social services requirements should be upgraded to require that each home with 100 beds or more employ at least one full-time social worker. For those homes with less than 100 beds, a minimum level (i.e. three-quarter FTE) of social services would need to be established. Upgrading the social service condition will improve the quality of life for nursing home residents.

QUALIFIED NURSING PERSONNEL

The IOM report recommends that nursing homes place their highest priority on the recruitment, retention, and support of adequate numbers of professional nursing staff. Qualified nursing personnel is a key factor indicating the quality of resident care. Yet, nursing homes generally experience high turnover rates among nursing staff. Although the AHFLCD recognizes that these high attrition rates may be associated with poor working conditions, heavy resident workloads, inadequate training, turnover rates may also be associated with insufficient wages or fringe benefits.

Generally, the wages for professional nursing staff and nurse aides in nursing homes are substantially below the wages paid by hospitals. Nursing homes should be encouraged to pay comparable wages to attract and retain qualified staff. Quality care and quality of life cannot be achieved unless nursing homes are able to recruit, retain and ensure that adequate numbers of nursing staff are provided to residents.

THE SURVEY PROCESS

The federal certification survey system needs to be redesigned to measure actual patient care and the quality of life. The present federal survey system does not assess quality care. It addresses the home's capacity to provide care and compliance with paper requirements. The evaluation of resident care should focus more on the resident rather than on paperwork review. Proper training of surveyors is critically important. The IOM report contains the following recommendations relating to survey:

- Consolidate Medicaid and Medicare survey procedures
- Timing of surveys should maximize the element of surprise. The elimination of time-limited agreements to permit flexibility in scheduling surveys
- Design and test two survey protocols; a standard survey and an extended survey
- Incorporate information on case-mix as derived from resident assessment data into survey protocols to take into account the differing characteristics
- A scientific sample of residents by case-mix; for both standard and extended surveys
- Survey residents using "key indicators" which measure actual services provided
- Require extended surveys for nursing homes which perform poorly on key indicators
- Emphasize interviews and observations of residents in assessing quality
- Require specific procedures and staff to properly investigate complaints of abuse and neglect
- Require HHS to establish additional survey procedures which require surveyors to meet with resident representatives before and after survey; that survey results be posted in a location accessible to residents and the public

- Recognize facilities providing excellent resident care
- Design survey protocols in accordance with recommended conditions and standards
- Test survey protocols (instruments and procedures) for validity, and
- Subject a sample of nursing homes to an extended survey.

The survey process should be modified to emphasize the recommended resident-centered, outcome-oriented standards proposed in the IOM report. The survey process needs to be redesigned to consider the differing care requirements of each patient, outcome and process measures of quality care, and consumer involvement. Surveys should be unannounced and maximize the element of surprise.

HHS has developed a new long term care survey process, formerly entitled PaCS (for Patient Care and Services). Briefly, the Long Term Care Survey Process evaluates the provision of services and resident outcomes by:

- observing the physical environment
- reviewing care provided to a sample of residents
- observing meal services
- observing drug administration for a sample of residents

The Long Term Care Survey Process is an improvement over the traditional federal survey process. It focuses on resident outcome rather than facility capacity and compliance with paper requirements. There remain, however, serious deficiencies in the new Long Term Care Survey Process survey system. Our support of the Long Term Care Survey Process system as currently proposed is contingent upon its revision to include the following elements:

- that the final form of any changes take into consideration the recommendations contained in the IOM report and other studies
- that HHS publish survey forms, interpretive guidelines and general instructions and make same available for general comment as part of the Notice of Proposed Rule Making or other process prior to implementation
- that HHS develop and announce detailed training plans for administrative and survey staff that will promote excellent and consistent implementation and administration of the revised process
- that the Long Term Care Survey Process include a sampling methodology and comprehensive standardized resident assessment procedure that will merit a high degree of confidence in survey findings and will successfully withstand critical professional and legal scrutiny
- that the Long Term Care Survey Process respect state-to-state variations existing between survey and certification activities and Inspection of Care programs and that appropriate funding is assured in the face of such changes
- that HHS allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers, and
- that a task force comprised of regulators, providers, health professionals and consumers monitor implementation and evolution of the Long Term Care Survey Process and assist in development of training materials, surveyor guidelines and public education activities.

The opportunity to modify the current system is welcomed. A constructive and collective effort on the part of the state and federal governments will provide for a process that will enhance our ability to measure service delivery to nursing home residents.

The integration of federal utilization control requirements with survey deserves careful consideration. A review by HHS is advisable and should involve states with superior waivers, and their experiences with unique systems.

FUNDING

The IOM report did not estimate the cost of the recommendations pertaining to elimination of the ICF designation, implementing a resident assessment system, strengthening the Ombudsman program, and redesigning the survey process.

The integrity of the nursing home survey process is dependent upon adequate funding. Presently, less than one percent of the federal Medicaid budget goes to fund nursing home inspections. The 1986 federal Medicaid budget for the entire nation is only forty-four million dollars. We concur with the recommendation of the IOM report which calls for reinstituting one hundred percent federal funding for nursing home certification inspections.

The Gramm-Rudman Act, and other efforts to reduce government spending, has ominous implications for the states' ability to perform surveillance. HHS is presently implementing cuts to selected state survey and certification budgets, consistent with the first round 4.3% spending reduction mandated by Gramm-Rudman. If implemented, Gramm-Rudman Round II would call for a further reduction of twenty-three percent.

We are very concerned about the present proposal to reduce federal matching funds for Medicaid program administration, in addition to further budget cuts. To reduce survey budgets now, when the federal government is mandating a new national survey process which requires additional resources, poses the gravest consequences for the nation's ability to monitor health care.

ENFORCEMENT OPTIONS

Federal Medicaid program requirements should include an effective array of enforcement sanctions. It is not in the best interests of nursing home residents that the only federal sanction is cancellation of the Medicaid contract. A contract cancellation forces the relocation of Medicaid residents, punishing the wrong party. Sanctions will assist the state and federal government in assuring quality care for nursing home residents. Sanctions needed are:

1. A Ban on Admissions. When resident care is substandard, a ban on admissions is a valuable enforcement tool. New admissions require a substantial amount of work. The ban protects the health and safety of residents by forcing the facility to target resources toward correction of deficiencies. Further, a ban on admissions creates a financial incentive and puts public pressure on the nursing home to achieve and maintain compliance with health and safety standards.

2. Civil Fines. Civil fines are an important enforcement option to program administrators. They have proven to be a valuable enforcement tool in numerous states.

3. Receivership. Receivership is a temporary action to protect the health and safety of residents. When a nursing home cannot meet the care needs of its residents, receivership permits the state to act as a manager of the home and as a trustee on behalf of residents until quality of care is restored.

HHS should be commended for its work to improve federal termination procedures. However, the procedures do not provide for appropriate responses to receivership actions or ownership changes. The problem is that, even if the nursing home provider is the source of the trouble and a new credible owner takes over, the new procedures still force the relocation of all Medicaid recipients.

HHS informs us the new procedures only apply to Medicare. Yet, they "recommended" the states use them in administering the Medicaid program. This ambiguity creates problems for the states. No federal regulations have been promulgated to apply these termination procedures to Medicaid. Moreover, the Medicare procedures are not consistent with Medicaid requirements. For example, they do no provide for an informal conference with the nursing home provider prior to termination, which is a clear requirement under the Code of Federal Regulations.

AUDIT CRITERIA

Federal officials have an oversight responsibility to ensure state programs operate within the broad statutory framework. This oversight is to ensure that service quality is adequate and that persons receiving services are eligible and have a medical need for services. However, federal Medicaid program audits have shifted away from helping states to improve care. The focus now is on citing technical deficiencies which result in severe financial penalties against the states.

The criteria for audits are seriously flawed; in that the audits simply measure whether there is one hundred percent compliance with thousands of paper and calendar date requirements. Anything less than one hundred percent compliance results in severe financial losses to the states. In our view, these penalties translate into less dollars available to meet the legitimate needs of Medicaid recipients. The current penalties are so draconian the audits have come to be viewed as a revenue trap against the states.

We recommend that federal requirements pertaining to paper compliance and calendar date requirements be modified to establish a five percent reasonableness level. In addition, HHS should provide prior written notice to states of new or modified criteria on which audits will be conducted and penalties assessed. We are anxious to work with HHS to improve the current requirement and to establish fundamentally sound audit criteria which relate to the ultimate outcome, quality patient care.

FEDERAL/STATE COOPERATION

The AHFLCD believes that implementation of the recommendations requires a strong federal/state relationship. The states are responsible for certification and licensure surveys, certificate of need, rate setting, and consumer protection. The combined resources and experience of the states regulatory agencies and by HHS should be utilized in implementing changes. Nursing home residents are the ultimate benefactor.

We strongly urge the federal government to be flexible in permitting states to implement program changes by waiver. In fact, some of the recommendations contained in the IOM report find their roots in effective state program waivers, requested and implemented by individual states. Continuing the waiver process will allow states to modify systems based on experience and knowledge and can further improve the quality care and the quality of life for nursing home residents.

FOLLOWUP

The AHFLCD strongly recommends the establishment of a national level mechanism for followup of any major changes to Medicaid requirements. Several different mechanisms could be proposed:

1) Formation of a national oversight task force; guided by HHS
2) Creation of a Congressional "watch dog" committee
3) Creation of an ongoing task force; composed of consumer and provider groups, and state and federal regulatory agency representatives.

Chairman HEINZ. Mr. Thompson, thank you very much. You are quite an expert on this subject.

Let me just announce, before I call on Ms. Edelman to testify, that I am going to ask Senator Wilson to make any comments that he has. I am going to have to go to another responsibility I have at 11:30, and Senator Pryor has graciously consented to conclude the hearing. I cannot think of anybody who has been working in this area and on these issues longer than my friend, David Pryor, so it is entirely fitting that he do a little time in the chair.

He informs me, by the way, Mr. Lopez, that when he was working as an orderly in a nursing home, he on occasion saw a few things to almost compare to what you showed us. That just means, I guess, that we must still work on these problems very hard indeed.

So, Pete Wilson.

STATEMENT OF SENATOR PETE WILSON

Senator WILSON. Thank you very much, Mr. Chairman.

I will not delay Ms. Edelman long, and I regret that three other commitments this morning caused me to arrive here later than I had hoped I could, and I have to leave in about 5 minutes for yet another.

I am particularly interested to see the film that Mr. Lopez showed. The testimony we have just heard from Mr. Thompson, I think, was not only eloquent, but forceful, borne of clear conviction. He is proposing some additional sanctions that sound difficult, tough, but in light of what apparently are the nature of the abuses, they may well be called for.

I would only say that looking at the testimony that is before us in these notebooks, it is clear that we are facing what is a growing problem because of the happy consequence of improved medical care, prolonging life, but generating an evergrowing need for nursing home care.

The real question, it seems to me, is one that I have heard Mr. Thompson discuss in his testimony here, and that is the need for quality as well as quantity.

In terms of the personnel involved in inspecting, it seems to me that that is an area where there is going to have to be even more attention given.

I have one question that I will ask at the risk of being naive. It almost sounds as though it is not likely that we are going to have an adequate supply of personnel for the purpose. And that is borne of the fact that there seems to be an inadequate supply of personnel with what is a growing universe of nursing home care requirements.

How would you propose, any of you, that we meet that need? It is a question both of money, but it is also a question of just finding people. And is it realistic to incorporate to a greater degree than has been done already, in a systematic way, the use of volunteers for that purpose?

Ms. DOYLE. Can I say something? I think, I believe it was Mr. Thompson, who had the answer. If there is any one thing that I believe would have changed the quality of the nursing home care that my mother received, it would have been having aides that were properly trained. There is a terribly high percentage of patient abuse that goes on unintentionally.

My mother's hand was neglected for that extended period of time, simply because her aides were not taught how to wash her hand while preventing my mother from taking her other hand and trying to pull at the aide and push her away.

Now, the process was not difficult. I finally figured out a way of doing it, and I washed her hand whenever I went. But why shouldn't her aides have known how to perform that task?

Also, regarding the contracture, all it needed to prevent mom's hand from further closing was for my mother's hand to be opened each day. This was the same kind of situation. It could have been done by the aide. Taxpayers did not need to pay for expensive physical therapy through Medicaid just to have someone open her hand. But because the aide was not trained to know how to do that or that it even should be done, mom's contracted hand was neglected to the point where it was almost amputated. This gap between mom's needs and her aides training affected much of mom's care . . . hanging a Foley bag above the waistline is another example, not realizing that such a move can cause serious problems.

There is nothing I found that could have improved Mom's care so much as well-trained aides. There is also not only the possibility of improving care by having aides properly trained and certified. I think if we Americans can apply our intelligence to things like working out systems for improved success in other businesses, why can't we work out systems for the business of providing nursing home care that will make the care of patients less expensive and more efficient, so that less people are needed to do the job? We desperately need improvement in the quality of nursing aide training.

Mr. LOPEZ. Senator Wilson, in California, there is a Certified Nurses Aide Program that commenced a couple of years ago. It is really new. It has in fact a basic requirement of training and other things that go with that. But even with that, our statistics show that in California there is over a 100-percent turnover in nurses aides even in nursing homes ranking up at the 75th percentile. So the remedy is something between an incentive ladder and something to get them to stay once trained. But on a national level, I would urge that the Certified Nurses Aide Program be strongly recommended or implemented, something along those lines. We have that.

Mr. THOMPSON. I believe your question had a larger scope, too, and that is, for example, in Washington State our occupancy rate is running 94 percent, which, for all intents and purposes, is full. We have before us demographics referred to as "the graying of America"—in my case, "the balding of America". The question is, How we are going to meet the growing needs of our elderly. With the advances in medical technology, people are living longer and staying healthier. They are going to live with more dignity if we can keep them in the most independent living setting possible. This means in retirement centers, congregate care facilities, at home with the meals-on-wheels programs, chore services and home health. It is important that we develop a full array of services in the continuum of long-term care. My testimony today deals more specifically with resident care in the nursing home, but there is a scope far beyond that which I think your question reaches. If we expect nursing homes to meet demographic demands, there is not nearly an adequate supply of nursing home beds.

Senator **Wilson**. It does, you are quite correct, although what I was trying to focus on was is the kind of care in a nursing home such that it is impractical to expect that, let us say, college-age volunteers, seeking to, if not gain credit, at least do something worthwhile as volunteers, might be trained at a certain level and be a dependable enough source of supply of manpower to make the difference that it seems to me is a widening difference?

Mr. **Thompson**. There are some very helpful programs. In our State, one home, for example, is having high school students as a part of their civic responsibility spend time assisting in the nursing homes. And it was reported to be very helpful. And I believe that there is room—obviously, voluntarism is part of what makes America so great—and we need to involve volunteers.

A second program that has been helpful in a number of homes is operating daycare centers out of nursing homes. The elderly people just love it. Pet therapy is another example. During a visit to a nursing home, I was going down the hall and noticed a patient in the corner. She had been in the home 3 days. She was not talking to anybody or adjusting very well. I stopped and bent down to talk to this lady. She would not converse. I had just walked out of a patient's room who had a cat I had been petting. Suddenly this cat appeared and jumped in her lap. She sprung to life. She loved it and began talking.

Ms. **Casper**. I would just like to follow up on that as well. I agree, there is definitely a role in the psychosocial, quality of life aspects, for voluntarism, but we must be careful to avoid the pitfall that, with the rising acuity level of residents and residents coming to long-term care facilities with extremely complex needs—people in nursing homes now that I never would have seen as a director of nursing 12 years ago—we must be careful that we do not allow untrained volunteer people to be allowed to enter into that arena.

Mr. **Thompson**. Yes; I agree.

Senator **Wilson**. Thank you, Mr. Chairman.

Senator **Pryor** [presiding]. Thank you, Senator Wilson.

Our final witness on this panel, Toby Edelman, is representing the National Senior Citizens Law Center. We look forward to your statement, Toby.

STATEMENT OF TOBY EDELMAN, STAFF ATTORNEY, NATIONAL CITIZENS LAW CENTER, WASHINGTON, DC

Ms. **Edelman**. Thank you very much, Senator.

This morning I have been asked to discuss the landmark Federal case *Smith* v. *Bowen*. That case overturned the Federal nursing home enforcement system and called for the Department to develop a new system that ensures that residents receive high-quality care.

The *Smith* case was filed in May 1975 by two nursing home residents who sued their nursing home, the Colorado Departments of Health and Social Services, and the Federal Department of Health, Education, and Welfare. The residents complained that the nursing home enforcement system fails to ensure that residents receive their entitlement under the Medicaid law to high-quality medical and psychosocial care in the context of full civil liberties.

In 1978, the Colorado defendants realigned themselves as plaintiffs and joined the nursing home residents in criticizing the Federal survey and certification system. The State plaintiffs called the Federal system, a national disgrace.

A trial was conducted against the Federal defendant in the spring of 1982, and a decision issued in February 1983. The district court recognized that the current system is appropriately characterized as facility-oriented rather than patient-oriented, focusing on the potential ability of a facility to provide care and not on the care actually provided to residents.

The court ruled that the evidence submitted at trial—both the voluminous exhibits and oral testimony—made clear that it is feasible for the Secretary to require States to use a different kind of system—a patient care management system that assesses patient needs and allows for monitoring of care actually received.

Despite these findings, the district court held that the Secretary does not have a statutory duty to compel use of such a patient-oriented system. The court found in essence that the Federal Government pays for care under the Medicaid Program, but that responsibility for the quality of that care lies solely with the States.

The court of appeals disagreed and reversed. In October 1984, the Tenth Circuit Court of Appeals held that the Secretary has a duty to establish a survey and certification system that enables her to inform herself adequately whether facilities receiving Federal money are complying with the law and providing high-quality medical care and rehabilitative services.

The tenth circuit decision makes two critical rulings: First, that there is a strong Federal duty to enforce compliance with the Medicaid law, and second, that the Medicaid law itself requires health care providers to give recipients high-quality medical care.

The Department's response to the Smith mandate was PACS, the new survey and certification system. The system is a new way of looking at facilities and of selecting information about them, and while there is generally universal support among consumers and providers for refocusing surveys on residents and the care they receive, the survey instrument and procedures have significant uncorrected problems.

For example, the guidelines do not tell surveyors how to translate the problems they observe into deficiencies they can cite. Nor do they explain how to select a representative sample of residents to interview indepth. Surveyor training is inadequate, and resident and public education on the new system is nonexistent.

The Committee on Nursing Home Regulation of the Institute of Medicine found other major deficiencies in the new survey protocol. Last month, 20 national organizations expressed continued concern with the new survey process. They urged the Department to establish a reasonable phase-in period for implementation; to improve initial and followup surveyor training; to revise the guidelines; to allow waivers to States with innovative survey methods and enforcement practices that exceed Federal requirements; and to establish a task force of regulators, providers, health professionals and consumers to monitor implementation and evolution of the new system. I have provided the committee with a copy of this statement of concerns.[18]

Even if the new survey system were the perfect tool, it would not be sufficient to meet the mandate of the Smith court. The survey process is only one part of the nursing home system to assure high quality of care and life to residents. To comply with Smith, the system needs to have the following components. First, good standards of care, including a condition of participation on the quality of life, as the Institute of Medicine suggested; second, effective methods for surveying and determining the quality of service provided—that is what the PACS system is all about; third, solid enforcement procedures to eliminate bad practices and promote good ones. This component calls for a full range of Federal intermediate sanctions we have been talking about this morning, such as receivership, civil fines, monitors, and so forth; fourth, adequate reimbursement properly focused on quality care and services, accountable to public scrutiny; and fifth, active public participation.

These five recommendations were unanimously endorsed in December 1985 at a work session on PACS held by the National Citizens Coalition for Nursing Home Reform, a national organization that participated in the *Smith* case as a friend of the court. I have also provided the committee with that resolution.[19]

The Institute of Medicine, I would note, made virtually identical recommendations in its report 2 months ago.

The Department has known for many years that the nursing home survey system fails to assure high-quality care to residents. Much of the plaintiffs' evidence in the *Smith* case was studies that were either conducted or commissioned by the Department in recognition of the inappropriate facility-oriented paper compliance nature of the survey process. The new survey system, while a good and important first step in the right direction, is not the total answer to the Federal Government's responsibility.

The Department needs to do more to assure that long-term care facilities provide their residents with high quality of care and life.

Thank you.

Senator PRYOR. Thank you very much.

[The prepared statement of Ms. Edelman follows:]

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[18] "Please see page 169."

[19] "Please see page 172."

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"NURSING HOME CARE: THE UNFINISHED AGENDA"

Hearing, U. S. Senate Special Committee on Aging
May 21, 1986

Thank you for the opportunity to testify before the Committee today. I shall very briefly answer the questions in the Committee's May 13th letter and expand upon the answers in written testimony that I shall submit for the record at a later time.

Smith v. Bowen was filed in May, 1975 by two nursing home residents who sued their nursing home, the Colorado Departments of Health and Social Services, and what was then known as the federal Department of Health, Education and Welfare. The residents complained that the federal nursing home enforcement system fails to ensure that residents receive their entitlement under the Medicaid law to high quality medical and psychosocial care in a context of civil liberties. In 1978, the Colorado defendants realigned as plaintiffs and joined the residents in criticizing the federal survey and certification process. The state plaintiffs called the federal system "'a national disgrace.'" In re Estate of Smith v. O'Halloran, 557 F. Supp. 289, 291 (D. Colo. 1983) (quoting paragraph 1 of complaint of plaintiffs in intervention).

A trial was conducted against the federal defendant in the spring of 1982 and a decision issued in February, 1983. The district court recognized that the current system is appropriately characterized as "facility-oriented," rather than "patient-oriented," id., 557 F. Supp. at 295, focusing on the potential ability of a facility to provide care, not on the care actually provided. The court ruled that the evidence submitted at trial--both the voluminous exhibits and oral testimony--made clear that it is "feasible" for the Secretary to requires states to use a different kind of system--a patient care management system that assesses patient needs and allows for monitoring of care actually received. Id. Despite these findings, the court held that the Secretary does not have a statutory duty to compel use of such a patient-oriented system. The court found, in essence, that the federal government pays for care under the Medicaid program but that responsibility for the quality of that care lies solely with the states.

The Court of Appeals disagreed and reversed. In October, 1984, the 10th Circuit Court of Appeals held that the Secretary has a duty to establish a survey and certification system that enables her to inform herself adequately whether facilities receiving federal money are complying with the law and providing high quality medical care and rehabilitative services to residents. Estate of Smith v. Heckler, 747 F.2d 583, 589-90 (10th Cir. 1984).

The Tenth Circuit decision makes two critical rulings: first, that there is a strong federal duty to enforce compliance with the Medicaid law; and second, that the Medicaid law itself requires health care providers to give recipients high quality medical care.

The Department's response to the Smith mandate was PaCS, an acronym standing for Patient Care and Services, a new survey and certification system now known simply as the Long-Term Care Survey Process. The system is a new way of looking at facilities and of collecting information about them. While there is universal support among consumers and providers for refocusing surveys on residents and the care they receive, the survey instrument and procedures have significant uncorrected problems. For example, the guidelines do not tell surveyors how to translate the problems they observe into deficiencies they can cite, nor do they explain how to select a representative sample of residents to interview in-depth. Surveyor training is inadequate and resident and public education on the new system is non-existent. The Committee on Nursing Home Regulation of the Institute of Medicine found other major deficiencies in the new survey protocol, including the failure to require facilities to maintain standard resident assessment data. The Committee on Nursing Home Regulations, Institute of Medicine, Improving the Quality of Care in Nursing Homes, 130-32 (1986).

Last month, twenty national organizations expressed continued concern with the new survey process. They urged the Department to establish a reasonable phase-in period for implementation, to improve initial and follow-up surveyor training; to revise surveyor guidelines; to allow waivers to states with innovative survey methods and enforcement practices exceeding federal requirements; and to establish a task force of regulators, providers, health professionals and consumers to monitor implementation and evolution of the new system. (I have provided the Committee with a copy of the Statement of Concerns.)

Even if the new survey system were the perfect tool, it would not be sufficient to meet the mandate of the Smith court. The survey process is only one part of the nursing home system to assure high quality of care and life to residents. To comply with Smith, the system needs to have the following components:

1. good standards of care, including a condition of participation on the quality of life, as the Institute of Medicine suggested;

2. effective methods for surveying and determining the quality of service provided;
3. solid enforcement procedures to eliminate bad practices and promote good ones (this component calls for a full range of federal intermediate sanctions);
4. adequate reimbursement properly focused on quality care and services, accountable to public scrutiny; and
5. active public participation.

These five recommendations were unanimously endorsed in December, 1985, at a work session on PaCS held by the National Citizens Coalition for Nursing Home Reform, an organization that participated in the Smith case as a friend of the court. (I have provided the Committee with a copy of the Resolution.) The Institute of Medicine made virtually identical recommendations in its 1986 report.

The Department has known for many years that the nursing home survey system fails to assure high quality care to residents. Much of plaintiffs' evidence in the Smith case was studies conducted or commissioned by the Department, in recognition of the inappropriate "facility-oriented" nature of the survey process. The new survey system, while a good and important first step in the right direction, is not the total answer to the federal government's responsibility. The Department needs to do more to assure that long-term care facilities provide their residents with high quality of care and life.

Toby S. Edelman
May 19, 1986

National Citizens' Coalition for
NURSING HOME REFORM

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April 9, 1986

STATEMENT OF CONCERNS

RE: HCFA'S NEW LONG TERM CARE SURVEY PROCESS (PaCS)

TO: Sharon Harris, Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau, HCFA

We are writing to express concerns about the implementation of the new Long Term Care Survey Process. We commend HCFA for initiating this important change in the way nursing homes are surveyed. HCFA's new long term care survey process is a positive and significant development in nursing home regulation. If implemented properly, it can tremendously strengthen HCFA's ability to monitor and assess the quality of care nursing home residents receive.

We support the process because it provides the opportunity to hear directly from residents about the quality of care and life in the homes. It focuses on the care residents actually receive rather than a home's compliance, in theory, with standards of good practice.

We recognize your agency's unprecedented efforts to share information about this new process and to solicit and incorporate recommendations for improvements. This openness has created an atmosphere for sincere discussion about how to develop a system that will best serve nursing home residents. We commend your proposed work plan which indicates continued agency activities which will contribute to an improved survey process. It is in the spirit of cooperation that we offer concerns and recommendations related to successful implementation of the new long term care survey process.

To be implemented and utilized successfully, this landmark change in nursing home regulation will require tremendous support and cooperation from federal and state regulatory agencies, nursing home providers and residents, and their representatives.

We recognize that it took a great deal of time and thought to develop this new system. Now the Health Care Financing Administration is endangering this new system with a poorly developed, unrealistic and potentially harmful implementation plan including:

(1) an unrealistic implementation schedule. States need more than two or three months to make the transition to the new procedures, format and skills required by the new system. HCFA is to be commended for postponing start-up until 30 days after publication of a Notice of Final Rule which it expects to publish by the end of April. A June start-up is much more reasonable than the planned April 1 date. However, HCFA is requiring that states totally assimilate the new process within two months of start-up.

(2) an inadequate approach to training. HCFA is training less than 10% of those who will conduct the new survey and relying on those representatives to return to their states and convey new federal policies and procedures to their co-workers. States will have to purchase training materials and duplicate training manuals in order to provide the basic orientation to their surveyors. The training itself lacks sufficient development in the area of communicating with confused (or those who appear confused) residents and with residents who manifest communication difficulties, yet such communication is essential if the new process is to work.

(3) incomplete guidelines and instructions to surveyors. Current surveyor guidelines, in draft form, are confusing and incomplete, and particularly weak in the areas of residents' rights, residents' social, emotional, and mental health needs and other quality of life areas. HCFA has acknowledged these problems and is revising the guidelines. Although surveyors must begin conducting these new surveys in June, revised guidelines for the survey process will not be completed until October 1.

(4) inadequate recognition of and cooperation with positive innovations and activities of state regulatory agencies. Many states already conduct resident focused, outcome oriented surveys and have a broader range of enforcement tools available to apply to poor homes. HCFA has told state agencies to follow the federal format and procedures without exception, or lose federal financial participation, and has expressed an unwillingness to coordinate with effective state enforcement practices.

We, the undersigned organizations, call upon the Health Care Financing Administration to give the leadership and support necessary to help this system work for the protection and welfare of nursing home residents, by taking action to:

(1) establish a reasonable phase-in period for implementation of this new process, beginning June 1 and continuing through December 31, 1986;

(2) provide direct federal training to every surveyor, to assure consistent direction and clear statements of federal policy;

(3) develop a plan for follow-up training beginning in January, 1987, and to supply training materials for every surveyor and each state agency, particularly in the areas of communication skills, residents' rights, residents' social, emotional and mental health needs, and determining what is a deficiency;

(4) maintain its commitment to revise surveyor guidelines based on the experiences and concerns of surveyors, providers, health care professionals, and consumers after all have had experience with this new process;

(5) allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and to develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers;

(6) work in partnership with regulators, providers and consumers to educate the public and maximize public participation in and understanding of the process;

(7) establish a task force of regulators, providers, health professionals, and consumers to monitor implementation and evolution of this new system and assist in development of training materials, surveyor guidelines and public education activities.

This new process is an evolutionary one. If implemented correctly, it can contribute to the many reforms in the system that are necessary - reforms that are addressed in the March, 1986 Institute of Medicine report.

Changes in the way surveyors conduct surveys will require changes in approach, in attitudes, in skills, and in experience. These changes are much too important to be lost by shortcuts during this critical implementation period.

Co-signers of the Statement of Concerns

American Association of Homes for the Aging
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Health Care Association
American Nurses Association
American Occupational Therapy Association
American Psychological Association
American Society of Consultant Pharmacists
National Association of Area Agencies on Aging
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Association of State Units on Aging
National Citizens' Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Senior Citizens
National Support Center for Families of the Aging
Service Employees International Union
Unitarian Universalist Association

National Citizens' Coalition for Nursing Home Reform

STATEMENT AND PRELIMINARY RESPONSE TO HEALTH CARE FINANCING ADMINISTRATION

Proposed Rules, October 31, 1985, Federal Register, Vol. 50, No. 211
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The National Citizens' Coalition for Nursing Home Reform, with support from the American Association of Retired Persons, conducted an 18-hour working session to review HCFA's PaCS proposal. Participants at the last day of the session, and subsequently, the NCCNHR Board of Directors, unanimously supported the resolution which follows. The resolution calls for a 60-day extension of the comment period to provide time to review the extensive materials necessary for reorganizing the survey process - many of which have only recently become available. It is important that the public have the opportunity to review and comment on these materials, just as HCFA has provided this opportunity for participants in the working session. The resolution views PaCS as an important step in the development of a sufficient survey-enforcement system, but one that is incomplete, in its present form, and is not now usable for certification purposes. The resolution also views PaCS in the context of the nursing home system and recommends significant changes in the total regulatory system before quality care for residents can be assured. NCCNHR urges HCFA-HSQB to continue to include consumers, providers, health care professionals, and other interested parties in the development of this system. HCFA-HSQB is to be commended for such activities thus far. A list of participants in the December 9-11, 1985 meeting is attached. (Participants who attended the final December 11 session are noted.)

RESOLUTION ON PaCS

Unanimously Supported by

Participants in the NCCNHR Work Session

December 11, 1985

and the NCCNHR Board of Directors

This resolution is passed in recognition and reaffirmation of the duty of the Secretary of the Department of Health and Human Services "to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities .... and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys." (as stated in Public Law 98-369, a 1984 amendment to the Social Security Act.)

According to the legislative background of this amendment, it is the intent of Congress that, "Protection of the 'health and safety of residents' and promotion of 'effective and efficient use of public monies' means that the Secretary must establish and enforce standards to achieve the goal of the Medicaid Act, that nursing home residents receive appropriate, high quality services to help individuals attain or retain capability for independence and self care."

PaCS in Context of the Nursing Home System

Assuring high quality care and services for nursing home residents requires a regulatory system with several essential components:

1) good standards of care

2) effective methods for surveying and determining the quality of service provided

3) solid enforcement procedures to eliminate bad practices and promote good ones

4) adequate reimbursement properly focused on quality care and services, accountable to public scrutiny

5) active public participation

A Consumer Statement of Principles for the Nursing Home Regulatory System, written by the National Citizens' Coalition for Nursing Home Reform and endorsed by 40 national and 250 state and local organizations, was submitted to the Secretary of the Department of Health and Human Services in September, 1983. This Statement of Principles elaborates the essential ingredients of an effective regulatory system, as follows:

1. To ensure that services are delivered to nursing home residents, the regulatory system must focus on the needs of residents
2. Standards for nursing home care must be objective, consistent, simple, and well-defined
3. The regulatory system must maintain accurate information about the quality of services provided to residents on a regular and ongoing basis
4. The enforcement system should ensure that providers, as a condition of participation in the benefits program, comply with the standards agreed to in the provider agreement. The system should have a variety of methods to encourage compliance
5. The regulatory agency should assure that nursing homes spend public monies efficiently and effectively to maximize their ability to provide quality care that meets the needs of residents
6. The system shoud ensure the availability of services to those in need without discrimination on the basis of race, sex, religion, diagnosis or method of payment
7. The regulatory system should promote development of a sufficient range and supply of services, including trained personnel, in sufficient numbers to meet residents' needs.

We reaffirm the principles contained in the document, copy enclosed.

Response to PaCS

PaCS (Patient Care and Services), the inspection process proposed by the Department of Health and Human Services on October 31, 1985, addresses one important part of this total regulatory system -- how information is gathered about the quality of services residents receive. We commend its focus on outcomes of care and its direct involvement of residents in the inspection process. This proposal offers potential for improving the inspection process, and its refocus on residents makes it an important step in the right direction. Yet it remains one step, which by itself, cannot provide the changes necessary to assure high quality care and services for nursing home residents.

In its current form, the PaCS system is not yet adequate for use in making legal determinations about whether or not a facility should be recertified for Medicare or Medicaid. PaCS presents a method for gathering information and screening for problems through discussion with a sample of residents on a sample of issues. It does not, in its present form, guide surveyors sufficiently to enable them to determine where a facility is deficient or what is an appropriate plan of correction. Moreover, it does not include adequate tools for enforcement of standards of care or assurance that each individual receives appropriate and high quality care.

Before PaCS can be used for certification purposes, its forms and guidelines need to be revised and reorganized significantly to provide more guidance to surveyors on how to register deficiencies based on what they observe. The forms should retain all the Conditions of Participation, and the elements and standards, each of which should be reviewed during each survey. Each section of the guidelines should be reworked to include a rights component and a psychosocial component. A more detailed discussion of preliminary recommendations on the PaCS materials and processes, including the resident sample, is attached.

HCFA should conduct an educational campaign to promote and support residents' participation in the survey process, through development and distribution of an explanatory brochure, and coordination with local ombudsman programs in work with residents and families.

Since PaCS is an important step in the right direction, HCFA should continue its evolution and development. Testing of PaCS instruments and training in the PaCS philosophy should continue and expand, so that HCFA and state surveyors can maintain the positive momentum towards PaCS and move close to implementation of this system. Training, particularly in communication and observation skills, should be conducted by HCFA for every surveyor.

Conclusion

As HCFA-HHS maintains its commitment to PaCS and continues development and progress on PaCS, HCFA should also begin efforts to reform the rest of the regulatory system. We support the work plan of the Acting Director of the Office of Survey and Certification (see attached) and urge the Department to progress in its efforts to build a regulatory system which truly assures high quality care and services for each nursing home resident.

NCCNHR will submit more detailed recommendations specificaly on PaCS to HHS-HCFA as soon as possible. The PaCS proposal is an ambitious one, the materials are complex and sensitive. Once again, we call upon the Department to extend the comment period by 60 days in order for the public to respond to this important proposal, particularly in light of the fact that key materials for the PaCS process have only recently become available.

We commend HCFA for initiating this important refocus of the survey process and urge the Department to approach needed reform of the entire regulatory system with a similar vigor.

Senator PRYOR. This has been a fine hearing. I do have a few questions I would like to ask. You shared an awful lot of information with this committee, and I want to thank you for that on behalf of the chairman and the members of the Aging Committee and the Senate.

But I want to share a little bit of information with you, if I might, at this time. I want to tell you about a poll that was taken in our State of Arkansas, completed only 2 weeks ago. One thousand respondents or citizens in our State were asked the following question: For what cause would you be willing to pay additional taxes? They had about 10 things: defense, help the farmers, help the schoolteachers, help small business, and on down the line.

By far and away, what the people of our State said they were willing to pay additional taxes for were for elderly programs, elderly programs. I think that probably is pretty representative and mirrors the feeling throughout this country of support for these programs.

My question, then, goes to Ms. Casper—and I imagine several on the panel could answer this. Is this money that the Federal Government is expending going to the nursing home owners primarily, or is it going for patient care? I know that is a difficult question, and I know that is a complicated issue.

I also would like to follow along with a question to you, if I might, on whether or not it is your sense that the nursing homes that operate for a profit versus nonprofit—and this question also to Mr. Thompson—whether you get fewer complaints from the nonprofits or those operating for a profit. We have not really gone into that this morning, but I wonder if either of you might touch on that?

Mr. THOMPSON. Senator Pryor, with respect to the profit and nonprofit facilities, in our State, clearly, the nonprofit facilities have higher staffing ratios because they have invested over a period of time in more staffing; we tend to have less complaints for nonprofit facilities.

With respect to where the funds go——

Senator PRYOR. That is a tough one, I know, and probably an unfair question.

Mr. THOMPSON. That is a very, very difficult question to answer. I would point out that nursing homes are doing well on Wall Street. Beverly Enterprises and others are buying nursing homes in Washington State above the appraised value. That was even after Congress passed the 1984 Deficit Budget Reduction Act that said they could not get an increase in reimbursement as a result of an ownership change.

Senator PRYOR. So are you saying that a for-profit nursing home is a good profit venture?

Mr. THOMPSON. I would say they seem to be doing very well.

Senator PRYOR. And getting better because the number of patients and residents will double in the next 20 years?

Mr. THOMPSON. Well, they are not like the corner grocer, who runs a real risk; they have got a guaranteed business.

Senator PRYOR. This is a completely different issue and I think that one of these days we ought to hold a hearing on it, because this is something that was pretty well gone unnoticed up to this point.

Mr. Lopez.

Mr. LOPEZ. Well, the occupancy rate in Los Angeles is approximately 94 percent.

Senator PRYOR. Ninety-four percent.

Mr. LOPEZ. Right. That is 400 nursing homes. And that is part of the problem. If you find a facility, it may be 80 to 200 miles away.

Senator PRYOR. Ms. Casper touched on an issue awhile ago, and that was reimbursement to the nursing homes. Let us talk about reimbursement to the employees of a nursing home for a moment. Let us talk about that orderly, or let us talk about that nurse, or let us talk about the attendant that is there over the weekend.

Are these people adequately paid?

Ms. CASPER. No. Clearly, I believe there is a problem with reimbursement for nursing home staff, and that was part of my first point. There must be competent staff to care for the increasingly complex residents—but how do you attract and maintain competent people in this environment? You do that by paying them and recognizing their worth. And I think it is definitely an issue.

Our firm has done some studies regarding pay, and typically, nursing assistants, whom, as you have heard, render about 80 percent of the care in facilities, are typically paid at the minimum wage, and the turnover rate is extremely high.

Senator PRYOR. If I might, let me ask Ms. Doyle a question. Do you believe that in your mother's case, Ms. Doyle, that your mother's care was adversely affected because she was a Medicaid resident or patient?

Ms. DOYLE. Well, in the last nursing home she was in, I do not think it would have made any difference whether she paid or she did not pay, because most of the patients in that home were on Medicaid; because of the conditions there, paying patients were few. And that is something that I seemed to find when I was going around surveying nursing homes for my mother; the openings were always in the worst places, which means that people who intend to pay but have an emergency situation that requires finding a nursing home quickly will find that opening in a nursing home that is one of the worst.

Senator PRYOR. Ms. Doyle and Ms. Dowling, you are both, by the way, very courageous to come here today, and I think your testimony was very worthwhile; let me say that.

Let me ask both of you this question. Let us say my mother was still alive, and I was searching for a nursing home—and I get this question constantly—what should I look for in a nursing home? What should we be looking for today in trying to find a home that renders the best care?

What criteria do you use? Or, can you walk in there and just say this is a good place, or this is a bad place? Can you sense that immediately?

I wonder if you would have a comment on that.

Ms. DOWLING. We based ours on how it smelled, how it looked, if it looked clean, how the patients looked; if the patients had a lot of company, it seemed like it was better. We also asked people that we knew in Napa who had people at a rest home or a convalescent hospital. And we checked with our large acute hospital in Napa, and they gave us names of ones that would be available. I would like to comment on one other thing, when you were talking about the Medicaid and that.

Senator PRYOR. Yes.

Ms. DOWLING. In the home that my grandmother was in, they brought in a lot of private people from like Kaiser Permanente Medical Hospital. Those patients had the best care. They would have nurses' aides in there every 15 minutes, checking on them.

Senator PRYOR. Now, why is that?

Ms. DOWLING. Because I guess it was a private—it was not somebody who was on Medicare or Medicaid. That is how I feel.

Senator PRYOR. They were paying individually, then, rather than from the Government.

Ms. DOWLING. Right.

Senator PRYOR. And so they got a higher quality of care; is that what you are saying?

Ms. DOWLING. Right.

Senator PRYOR. Ms. Doyle.

Ms. DOYLE. This was my experience as well, in the early nursing home in Florida. When my mother was a paying patient, her care was good. As soon as she went on Medicaid, she was moved to another section of the nursing home, and her care level dropped. The nursing staff was not as capable as the nursing staff on the other side, and she just received a poorer level of care.

Senator PRYOR. Were either of you ever aware of State or Federal inspectors in the homes while you were there, helping and assisting your mother and your grandmother? Were you aware of Federal inspectors, and if so, did you go to them and register a complaint? Or, you never saw an inspection while you were there——

Ms. DOYLE. I realized after I came in contact with other people in the investigation of her last nursing home that some of the people I occasionally saw were inspectors. And had I known that, I would have had more courage to speak out and would have talked to them. But I had no way of knowing who they were when I saw them.

Senator PRYOR. I see.

Did you find that the families of other patients in the home had a fear of complaining?

Ms. DOYLE. Definitely.

Ms. DOWLING. Yes.

Senator PRYOR. By the way, Ms. Casper, do you find this—and I also would ask Toby Edelman this—are you finding that there is an increasing amount of fear in the nursing homes for people who complain?

Ms. CASPER. Increasing fear of reprisal for complaining?

Senator PRYOR. Yes.

Ms. CASPER. I cannot personally attest to that, but I do know that the new PACS process has made strides in this regard in that a very large part of PACS is a confidential resident interview. And if the interviews are accomplished the way we would hope that they will be, they will get at that issue.

Senator PRYOR. I see.

Toby.

Ms. **Edelman**. It is inevitable that there is tremendous fear on the part of families and residents. That is one reason why it is very important that the Federal and State systems be aggressive and active, because the residents and families are, in many instances, unable to speak up, or afraid of speaking up on their own behalf.

The New York attorney general just filed a case against a nursing home for using a private pay duration of stay contract, which requires the family to pay privately for 18 months, instead of accepting the Medicaid rate. In the press release announcing that lawsuit, the attorney general says, "We are unable to get too many complaints from people because they are afraid, but we understand that this happens a lot."

Senator **Pryor**. I see.

Mr. Thompson.

Mr. **Thompson**. Yes, there is another form of fear of reciprocity, and that is the staff who work in the nursing homes.

Last week, I met with five nursing assistants from the State of Washington all afternoon, and when they first came to meet with me, they just wanted me to know their first names. When they left, they felt a little better. Reciprocity was one of their key concerns.

Senator **Pryor**. In other words, the staff was afraid to tell what was going on in the particular home for fear of losing their jobs or whatever.

Mr. **Thompson**. Yes. There should be a mandatory statute on anonymity and confidentiality in those cases, and provision for criminal prosecution when reciprocity, takes place.

Mr. **Lopez**. Even with our so-called guarantee of confidentiality, of the last 5-year average 1,500 complaints, I would say fully one-third were anonymous, and they went to great lengths to conceal exactly who they are, to protect that confidentiality, because of the fear of retaliation.

Senator **Pryor**. We have a great deal of trouble today with our Department of Defense. They do not like whistleblowers. And this is true, I guess, in the nursing home industry as well.

I have a question for you, Mr. Thompson. You brought some new and very fresh information in your statement today that the committee was not aware of. What has been your experience with the implementation of the new long-term case survey process? What has been your actual experience with that?

Mr. **Thompson**. First of all, Washington State residents have been benefiting from an outcome-oriented survey process for 5 years under a Federal waiver requested by the State of Washington.

If your question gets at what has my experience been in trying to implement PACS and the new Federal long-term care survey process, unfortunately, I regret to report today it has not been a very good one.

We were asked to survey only homes that had no problems. We were told to implement the new system on January 1 with no training. Then we were told we were going to all get training materials. We did not get them; we received only one copy.

Senator **Pryor**. Who is responsible for that?

Mr. **Thompson**. The Health Care Financing Administration.

Surveyors in Washington State were trained approximately 30 days ago. The implementation has been delayed and delayed again, and I have a gap of time between training and implementation of the new process. This is very undesirable.

And then, I am more discouraged to report today—and I have been a supporter of moving to an outcome-oriented survey process, and particularly in those States that do not have an outcome-oriented process—that looks at actual patient care, because we need to make that first step forward, and I guess that is where I agree with Dr. Roper.

On May 15, I received the new survey forms. I had them evaluated by nine surveyors and two managers. I left a copy with your staff today.[20] Survey staff are tremendously upset; in fact, they asked me to consider getting a court injunction to stop the use of this new form. Our surveyors were excited about trying the new process, until they saw the new form.

Senator PRYOR. How lengthy and complicated is the new form?

Mr. THOMPSON. This yellow document is the form, and this is the analysis of it. It reduces services for ICF patients; it changes requirements; it confuses their tag numbers. I encourage you to have your staff look at it carefully.

When surveyors are concerned, I am concerned.

Ms. CASPER. May I make a followup comment, Senator?

Senator PRYOR. Yes.

Ms. CASPER. We have lived and breathed PACS since 1984. We developed the original training, the draft that HCFA was going to be using for training its surveyors. But HCFA is utilizing a "train the trainers" concept that was completed in March. Essentially, 300 of our Nation's 2,000 long-term care surveyors will be trained by this trickle-down theory.

And what is happening is that we have contracts now with 19 States to train provider—providers, not regulators—in the new process. The regulators are just now coming to grips with the fact that they indeed are not ready or prepared to deal with this new process. Within the last 6 weeks, we have gotten contracts from two State licensure agencies who say, "Help. You developed the core of the training for PACS. Please come and help us figure out how to implement it."

In addition, when we are presenting to providers, we always encourage that the State licensure agency be there, because it is critical that they discuss how State licensure and Federal certification is going to interface. Most of the States have declined simply because they say, "We have absolutely no idea how on earth we are going to implement this new program." And it is a real concern.

Senator PRYOR. Well, you have both given very good testimony on that point, and something for this committee to consider.

Mr. Lopez, I got the idea from your testimony that you had established sort of a team of crack troops, or maybe an "A team", or "SWAT team", whatever you want to call it.

Mr. LOPEZ. Yes, we call it the enforcement surveillance.

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[20] "Please see volume II, appendix 6, p. 406, letter to HCFA dated June 28, 1985."

Senator Pryor. Let us say we tried that on the Federal level—who would we hear from in opposition to that?

Mr. Lopez. Well, you can rest assured that you would hear from the National Association of Homes—in California, the California Association of Health Facilities and their national offices—anything that goes to a heavier enforcement and their national counterpart is going to come back and say, "Look, you are violating a law"——

Senator Pryor. Did they actually oppose your doing this?

Mr. Lopez. Absolutely. If we did not have a certain sense of autonomy in being a county, and a large county politically, we would probably have been deep-sixed about 4 or 5 years ago, in terms of end runs that were made directly to our State offices. Those end runs continue on the administrative side—State licensure, anything else that goes with that.

But we have fortunately been able to put together a political coalition of all parties with the coroner, the public guardian, the district attorney, the city attorneys and health facilities division itself, to withstand any kind of real pressure.

In fact, I was looking at our statistics before I came, and we have prosecuted at least 46 cases in the last 5 years, and we do not consider that a lot. But when you compare that to other States and other regions, who have either one or zero, it makes us look as if we are out there, the "A-team," as it were. We think that that is just part of the total balance, and that we have not gone completely overboard in any one direction or the other.

Senator Pryor. We have a Humane Society that looks after animals, and it looks like we could have something similar to look after humans.

Mr. Lopez. Well, half the evidence disappears if you do not coordinate with your medical examiner. We have for the last 5 years, statistics on each and every death in every nursing home and hospital in the county of Los Angeles. We have routine meetings with our counterparts. We have checkpoints at the emergency rooms for this dumping in either direction.

Unless you do that, even if you thought there was a case, you will not have the evidence—things that we discovered 4 or 5 years ago, or even longer, I think. I keep using 5 years, but I am sure it is longer than that.

Senator Pryor. The videotapes that you brought to the committee today were most effective. Now, what has been the impact of this type of evidence-gathering that you have involved yourselves in?

Mr. Lopez. Well, even before we issued any kind of a deficiency, we heard about it from our State capitol that there was a bill introduced—there are two bills, one of which was killed, and the other one that is somewhere wending its way in terms of attempting to eliminate this as evidence. We think we can overcome that. But we had not even issued the deficiency, and there was already the opposition.

Senator Pryor. Well, was it the nursing home industry that opposed this?

Mr. Lopez. Yes, it is the industry. In the State of California——

Senator **Pryor**. So it is sort of a privacy issue? Was that brought up in the court case?

Mr. **Lopez**. Yes. It is the old thing that we have violated privacy to the point that we are the violators of patient rights and their privacy.

Ms. **Casper**. May I follow up on that briefly, Senator Pryor?

Senator **Pryor**. Yes.

Ms. **Casper**. Because Wisconsin also has a very stringent regulatory climate, and we do have a special enforcement resources unit, of which I was a part in my other life, and it was very successful. But the key issues are that you must have competent, capable, well-trained people—attorneys, nurses, professional people who know how to gather data, how to present in court, and how to win cases.

I am touching on the two points I talked about before, and you also must have strong management of the State licensure agency that supports these people, and rules and regulations that allow for litigation of these issues. But it can be done.

Senator **Pryor**. Thank you.

Toby.

Ms. **Edelman**. One problem with trying to translate what the States are doing effectively is that the Federal system does not have appropriate intermediate sanctions. Even if the Federal Government went in with the fast-track termination, or the "look behind," or any of those things, all they can do is say, "We are decertifying you." And that does not help the residents, because as you said, there is no place for the people to go.

What we need in most of the situations is systems and mechanisms that will improve those facilities. We have pretty much closed the firetraps and the dangerous facilities that need to be closed. The kinds of deficiencies and problems we see now can be corrected by having trained staff, by having somebody who knows what to do. The Federal sanction is just totally inadequate. We need to have a much broader range at the Federal level, as we do at the State level.

Senator **Pryor**. Well, let us see. I am just thinking out loud. We have, what—four-star or five-star restaurants—we grade restaurants with stars. We grade movies with stars. Do you reckon we ought to grade nursing homes and say this is a five-star nursing home, or a minus-two-star nursing home? Should that occur?

Ms. **Casper**. That is happening in the State of Illinois with their QUIP Program.

Senator **Pryor**. How is it working?

Ms. **Casper**. Mixed results. But we get back to the central issue, which is that you can have this wonderful program, but if you do not have people implementing it in a consistent, fair, and knowledgeable fashion, it matters not. Essentially, that is what we have found with QUIP.

Senator **Pryor**. I see.

Mr. **Thompson**. It is also misleading. We have a local consumer group in our State that puts out a rating guide. They listed a home as one of the best in the Seattle area, and by the time the guide came out, I had them in a decertification action.

Senator, was your prior question the question I have been waiting for on how we deal with substandard homes?

Senator **Pryor**. "P-r-i-o-r" or "P-r-y-o-r"? [Laughter.]

Go ahead.

Mr. **Thompson**. On how we can deal with substandard homes, I have some recommendations.

Senator **Pryor**. Yes. That was my first comment this morning, I think, was the sanctions; how do we do it? What do we do?

Mr. **Thompson**. First of all, it is critically important that we have adequate funding, enough staff to do inspections and take enforcement actions and enough surveyors to conduct surprise surveys.

Two, we need civil fine capability.

I'm not just talking about violation of rules, but also for repeat deficiencies, the kind of fine where, when you fine a home, it hurts.

Having said that, I want to recognize we are talking about the bad actors today. I have the deepest appreciation for the difficult and challenging jobs held by nursing home staff.

Senator **Pryor**. I do, too. I would like to say that, too.

Mr. **Thompson**. By far and away, most providers are trying to do the best possible job they can. But this percentage, this 30 percent or whatever amount it is we are talking about, demands effective sanctions. I am saddened and sickened by what I have seen and heard here today. When conditions are so deplorable, we should close the home. By God, we should prosecute those responsible.

Senator **Pryor**. OK, right there—where do the patients go?

Mr. **Thompson**. I had to close a nursing home and place the residents in three hospitals until the problems were resolved. I say take residents out of such deplorable conditions or put them in receivership.

Senator **Pryor**. Where is receivership being utilized; what States?

Mr. **Lopez**. In California.

Senator **Pryor**. How is it working?

Mr. **Lopez**. Not very effectively. It depends on a local judge who may decide what terms go with this generic term called receivership, and it may be as complicated as having two different people in there, not agreeing on a day-to-day basis.

There is a famous case involving Morro Bay Convalescent Hospital, and it has not worked out at all in this case.

Ms. **Dowling**. But, Senator——

Ms. **Edelman**. If I may——

Senator **Pryor**. Yes.

Ms. **Edelman**. We all want to stay here for hours. The first time the State of California used its receivership authority against a nursing home, it was, at least to some extent, successful in starting to improve conditions in the facility. But at that point, the receivership was basically a red flag to HCFA—this is a deficient facility. HCFA came in and terminated the facility but that action did not seem to be appropriate, at least at that time, because new staff had been brought into the facility and conditions had improved. It was a rural facility where there was no place else to move the people. The people we've talked to there agreed that 6 months, 1 year before, it had been very, very bad. But at the time of the receivership, at the time of the Federal action, conditions had improved. The Federal action was not helping.

Mr. Thompson. I have two more recommendations.

Senator Pryor. I must urge you—because I have got to go now—I must leave.

Mr. Thompson. I will make them very quick. I hope Dr. Roper is still here.

Senator Pryor. If he is not, I will bet some of his staff people are.

Mr. Thompson. Good. I am going to give them a copy of our analysis and this form, too.

Senator Pryor. Very good.

Mr. Thompson. They can combine the title 18–19 certification process. Right now, the Federal Government is in the business of doing certifications. Half the homes in our State are Medicare-certified. Alaska sends their certification paperwork to Seattle, and the Federal regional office certifies Medicare homes based on a paperwork review. They should say to the State, "You do the certification of Medicare. We will contract with you." They should make their focus very clear, focus on monitoring the State's performance and their look-behind authority, and not be doing certification. That would help.

The last recommendation, and an important one, is we need to integrate or bring the whole utilization review and control requirements under the licensing and certification entity. There are staff in nursing homes doing things the survey agency does not even know about. You can bring them together and get a better picture in time of what is going on in the nursing homes and better monitor the quality of resident care.

Senator Pryor. A very good point.

Do you agree with that, Ms. Casper?

Ms. Casper. Absolutely.

Mr. Lopez. One last thing.

Senator Pryor. Mr. Lopez.

Mr. Lopez. There is no central clearing system when you want to talk about a potential provider, not only within our State, nor within any part of our region, or region to region. I do not know for the life of me how somebody can keep up with what Texas is doing or Arkansas, if we are getting your bad actors, or you are getting our bad actors—not only in terms of individuals, but cleverly disguised or created corporations who can create new shells only as a fiction to move on to another region.

Senator Pryor. Once again on behalf of all the committee, I want to thank you very much, each of the witnesses who have come today. This has been a very constructive session, very informative. All I can say is that we have our work cut out for us, if we are going to make the changes that we have got to make.

We thank you, and the committee is adjourned. We are going to keep the record open for 2 weeks so that members of the committee who might have additional questions could submit those questions in writing, and we would very much appreciate your cooperation.

Mr. Thompson. Senator, 5 seconds.

Senator Pryor. Yes.

Mr. **Thompson**. I would plead before this committee today to do something about Federal utilization control penalty provisions which are taking legitimate funds away from Medicaid recipients. I have provided you with written testimony, and you have a letter from two national groups on the issue. Attached is a listing of the penalties levied against the State represented on this committee.

Thank you.

Senator **Pryor**. I thank you very much, and I know the committee does.

Thank you all. We are adjourned.

[Whereupon, at 12:07 p.m., the committee was adjourned.]

APPENDIXES

APPENDIX 1

CORRESPONDENCE AND ADDITIONAL TESTIMONY RECEIVED FOR THE RECORD

Item 1

STATEMENT FOR THE RECORD

RICHARD P. KUSSEROW

INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ON

NURSING HOMES PARTICIPATING

IN THE MEDICAID AND/OR MEDICARE PROGRAMS

MAY 21, 1986

Mr. Chairman and members of the Committee, I welcome this opportunity to discuss some of the work we have done relative to nursing homes that participate in the Medicaid and/or Medicare programs. As you know, Mr. Chairman, much of this work, particularly those efforts that I will be discussing, came about as a direct result of your request that we examine circumstances surrounding a nursing home in your home state of Pennsylvania.

We have issued three draft reports to the Administrator of the Health Care Financing Administration (HCFA). Each report focuses on one aspect of this very complex issue of nursing home/long-term care. The testimony elaborates on each report.

In one report, we recommended that HCFA strengthen its Medicare/Medicaid Automated Certification System (MMACS) to improve its monitoring of nursing homes. In another report we recommended that HCFA issue final regulations implementing the alternatives to nursing home decertification provisions of the Omnibus Reconciliation Act of 1980. In this report we recommended that HCFA expand its experimentation with swing-beds to large urban hospitals to increase the availability of nursing home beds and relieve the patients from having to settle for less than standard quality of care. We will make a copy of each report available to the Committee when completed in final.

BACKGROUND

Nursing home care is one of the fastest growing components of health care expenditures. In 1960, cost of this care totaled about $6.5 billion or about 1.9 percent of total health care expenditures. Twenty-four years later, nursing home expenditures jumped to $32 billion or 8.3 percent of total expenditures. As might be expected, the number of nursing homes and beds have also increased; jumping 161 percent and 688 percent, respectively, over the last 20 years.

This has had an enormous impact on Medicaid as it now spends about 31 percent of its total expenditures (about $14 billion) on nursing home care and accounts for nearly 50 percent of all nursing home expenditures in the United States. In terms of recipients served, Medicaid supports about 1.4 million patients in nursing homes throughout the country. Medicare, on the other hand, expends less than one percent of its total expenditures on nursing home care and accounts for about only 2 percent of all nursing home expenditures.

With the growth in nursing home facilities and Federal and State expenditures for care provided by these facilities, one would expect an ample supply of nursing home beds would exist. Unfortunately, this is not the case. Today our nation's nursing home industry enjoys a "seller's" market.

Bed occupancy rates exceed 90 percent and experts are in general agreement that there are serious shortages of nursing home beds throughout the country. Demographic projections indicate that the demand for beds will continue to grow as our population continues to "gray."

The shortage of nursing home beds is no excuse for accepting and/or condoning the participation of substandard nursing homes in the Medicaid and Medicare programs. However, the lack of competition creates no incentives to improving the quality of nursing home facilities. Both the Federal and State Governments share responsibility for identifying substandard nursing facilities and for ensuring that the homes correct their deficiencies timely or are removed from the programs.

Mr. Chairman, you have, on many occasions, expressed similar views. In your communications to me, you have expressed serious concern about the health and safety of patients in one particular nursing home in Pennsylvania. You requested that we review this situation and determine whether this was an isolated case or symptomatic of a widespread problem.

The following description discusses the actions taken in response to your request. These actions include our review of the particular nursing home as well as our evaluations of HCFA's role in:

...Identifying substandard nursing homes participating in the Medicaid and/or Medicare program.

...Taking action against substandard nursing homes after they have been identified.

...Increasing the nursing home bed-supply through use of hospital swing-beds.

Before going into detail, however, it should be made clear our findings do not appear to be isolated to the case you brought to our attention. We are able to document that nursing homes providing substandard care continue to participate in the Medicaid and Medicare programs long after HCFA or the States have identified them as being substandard.

Around the time we received your request, several actions had already been taken against the nursing home in question, including the Pennsylvania Department of Health restriction on its license by banning all new admissions and recommendations that the home be excluded from Medicaid reimbursement. HCFA had also terminated the nursing home from the Medicare program. These actions were done for failing to comply with Federal certification compliance. Four surveys done in an 11-month period uncovered a total of 303 deficiencies at the nursing facility. They also failed 8 conditions and 49 standards dueing the same time frame.

The nursing home, however, remained open. Your concern was for the immediate safety and physical well-being of patients still there and that was central to our initial efforts. Our staff inspected the nursing home and found no immediate signs of physical danger to patients. This included a physician on our staff who also reviewed medical records and observed overall conditions.

We further arranged for an independent physician review team from the American College of Utilization Review Physicians to conduct a more detailed review of conditions at the nursing home.

A follow-up team of three physicians visited the nursing home and made a more in-depth review of medical records. They interviewed patients, nursing home staff and the attending physician. Their opinion was that the health and safety of remaining patients were not in peril. A copy of their report was submitted to the Committee's staff.

We also made a financial audit of the nursing home. In a report on our audit of the home's Medicaid cost reports, we pointed out that unless its cost reports were adjusted during the final settlement process, the nursing home would be reimbursed $149,010 more than allowable by law. The State Medicaid agency agreed to consider our findings in its settlement process. A copy of our final audit report was also submitted to the Committee's staff.

Unfortunately, failure of a nursing home to meet Federal conditions of participation is not uncommon. A HCFA-funded study of policies and regulations governing certification of nursing homes made by the Institute of Medicine chartered by the National Academy of Sciences disclosed that State regulators reported having chronic problems with 10 to 15 percent of their nursing homes which they called "roller-coaster", "yo-yo", "in-and-out", or "borderline" nursing homes.

According to the study, these labels refer to nursing homes that are chronically out of compliance when surveyed, temporarily correct their deficiencies under a plan of corrective action, and then lapse into noncompliance which is again uncovered by the next annual inspection. Because of this pattern, substandard homes can remain in the programs for years while providing less than adequate care to patients.

Another indication of the scope of the problem of substandard homes is that, in the same study, HCFA was quoted as estimating that 5 percent of skilled nursing facilities will fail to meet one or more conditions in their current and next two certification surveys and 14.6 percent of ICF's will fail the same test.

Since there were indications that the problem of substandard nursing homes was national in scope, we evaluated HCFA's Medicare/Medicaid Automated Certification System (MMACS) --a national control mechanism designed to assist in monitoring States' survey and certification activities. Implemented in the early 1970's in response to an ever increasing demand for a centralized data source, MMACS is an automatic data retention system that provides information on the quality, quantity and availability of health care related services in the United States.

Our review showed that MMACS had not reached its full potential. Visiting eight HCFA regional offices, our audit staff learned that HCFA regional employees did not fully utilize MMACS because some considered the information it contained to be outdated. Our testing of MMACS verified that the data it contained was oftentimes out of date and, therefore, not as useful as it should have been.

As of January 1, 1985, MMACS contained 3,849 nursing homes that, according to the latest data inputted into the system, had not been surveyed within the last 15 months. This appeared to be a very serious matter indeed in terms of both protecting the health and safety of patients in these homes and misusing Federal funds. As you know, nursing homes not surveyed annually are not authorized to receive Federal reimbursement.

To determine the true situation with regard to both MMACS and State survey and certification activities, we reviewed case files for over 1,500 of these nursing homes located in 14 States. Contrary to what was recorded into MMACS, 96 percent of the homes had been surveyed within the last 15 months but the results had not been entered on MMACS. This occurred because it took too long for States to forward survey information to HCFA and for HCFA to input the data into the system. All told, an average of 107 days was required -- 73 by States and 34 by HCFA -- to input the data.

In our draft report to HCFA, we recommended that MMACS be kept as current as possible so that it could function as it was intended to. I would like to mention just a few ways HCFA could use MMACS to monitor nursing homes throughout the country and to meet the challenges arising from the Omnibus Reconciliation Act of 1980.

MMACS, for example, could be used to develop a national strategy to monitor State compliance with the requirement for annual surveys of nursing homes. In this regard, MMACS could identify States that have the highest incidence of noncompliance and these States would then be selected for review regardless of what HCFA region they were located in. MMACS could also be used to identify nursing homes that should be subject to HCFA inspections authorized under the Act.

MMACS could also be used to identify substandard nursing homes that, based on their history of noncompliance with Federal regulations, should be closely monitored. To show that such a task was feasible we used MMACS to identify skilled care homes that had repeatedly failed one or more of 7 conditions and 25 standards (there are 18 conditions of participation and hundreds of standards and elements that must be met by skilled care homes) we felt most related to patient care.

We recognize that the conditions and standards such as medical direction, physician services, etc. appear rather impersonal and it's difficult to relate them to the health and safety of nursing home patients. The Institute of Medicine, under a contract with DHHS concluded that two of the conditions which we selected were those "which could perhaps be tolerated during a brief hospital stay, but become intolerable and harmful to well-being when they are part of an individual's day-to-day life over a longer period." This is very strong language and clearly points out the significance of nursing home deficiencies.

Once we selected the conditions and standards, we then established the following parameters and designed programs to identify skilled nursing homes in MMACS that failed one or more of them. The parameters established were:

...Failure of any one selected condition in two or more consecutive surveys.

...Failure of any one selected condition two or more times.

...Failure of any one selected standard three or more consecutive times.

...Failure of any three or more selected conditions in any of the last three most recent surveys.

There were 740 skilled nursing homes that failed one or more of our parameters. In total, there were 972 parameter violations. There were 44 nursing homes that failed the same condition in the last two most recent surveys according to MMACS.

We provided HCFA with a list of these 44 skilled nursing facilities for follow-up action. Our whole point in citing these homes was that the homes had exhibited the "yo-yo" characteristics mentioned in the Institute of Medicine's study; that is, an annual survey found them to be out of compliance with a condition; they gained compliance through a plan of corrective action; and they lapsed back into non-compliance and failed the same condition as before.

We believe that nursing homes displaying past patterns of noncompliance require close scrutiny to ensure against future lapses into noncompliance. A smooth functioning MMACS could be the foundation for this scrutiny. This function will be even more critical then it is now once HCFA implements the alternative to decertification procedures.

In responding to our draft report on MMACS, HCFA agreed there were a number of useful findings which will be used in the overall effort to improve MMACS. One of the improvements mentioned which we find most interesting is that within two years States will be entering survey results directly into the data base. HCFA's ultimate goal is to have a "paperless process" in which surveyors will use hand-held computers to collect information about a facility, its patients and its compliance and then transmit the data to the States and HCFA regional offices.

Once these improvements have been implemented, keeping MMACS current should no longer be a problem. MMACS will then be the effective management tool it was intended to be.

Identifying substandard nursing homes is just the first step in protecting nursing home patients. The next step, and perhaps the most important, is doing something about substandard homes after they have been identified.

Congress has continuously expressed concern that many substandard facilities were allowed to continue in Medicaid and Medicare because termination was oftentimes neither feasible nor desirable in view of nursing bed shortages and the possible trauma that relocation often causes the elderly. Therefore, the Omnibus Reconciliation Act of 1980 provides alternatives to nursing home decertification provisions which allow the Secretary to deny reimbursement for a period up to 11 months to substandard nursing homes for new admissions in lieu of the more drastic sanction of terminating homes' participation in Medicaid or Medicare. This sanction was intended to encourage substandard nursing homes to quickly correct noted deficiencies.

The new sanction did not in any way lessen the Secretary's authority and responsibility to terminate facilities when conditions represent "immediate jeopardy" to patients. In these cases, the Secretary is to begin termination procedures immediately and halt further reimbursements for new admissions.

HCFA has not issued final regulations implementing the intermediate sanction provisions. A notice of proposed rule making issued on February 21, 1985, was reviewed by my office and found to be in general accord with the legislation. In a draft report to HCFA, we recommended that the final regulations be issued implementing the alternative to decertification provisions authorized by the Omnibus Reconciliation Act of 1980 as soon as possible after giving consideration to the changes we outlined in the report. HCFA responded by stating that more definitive guidelines on when to terminate or apply the intermediary sanction will be included in instructions to States and that time frames to complete the sanction process will be established. I'm pleased to report that significant progress towards resolving this has been made and the final rule should be published shortly.

We believe the intermediate sanction can be helpful and the sooner it is implemented, the better. The Institute of Medicine reported that the New York HCFA Regional Office had applied the sanction and found it effective in "coercing compliance with certification regulations". If this is, in fact, the experience of the New York region, it is certainly a positive indication that the sanction can be applied successfully.

We believe, however, that application of the sanction should be closely monitored by HCFA to ensure uniformity and consistency in the process and to measure its effect on "yo-yo" type homes described in the Institute of Medicine's study. According to legislative history, Congress intended that a facility would have the opportunity to develop and implement a plan for correcting its deficiencies. The Secretary could impose the intermediate sanction only after the facility failed to meet this requirement. This process gives "yo-yo" homes the opportunity to clean up their act through its plan of correction and to lapse right back into noncompliance. If this pattern continues in spite of the intermediate sanction, further measures including legislative changes may be needed.

Mr. Chairman, we testified that nursing home conditions across this country could be improved through better means of identifying substandard facilities and application of the intermediate sanction. Another, perhaps less direct method, would be to increase the supply of nursing beds available to Medicaid and Medicare patients in order to foster competition within the industry. In turn, competition could lead to improvements in the quality of care provided to nursing home patients.

Expanded use of hospital swing-beds could help alleviate the nursing home bed shortage and permit wider choice of nursing home beds that meet appropriate quality standards and would also benefit hospitals, the nation's economy and, most importantly, the nation's aged, infirm and disadvantaged who depend on Medicaid and/or Medicare for their health care.

In 1973, the first swing-bed program began in Utah as an experimental program funded by the Department of Health and Human Services. Under this experiment, hospitals were permitted to use beds to provide either acute hospital care or long-term care depending on specific medical needs of patients -- hence the term swing-beds. The purpose of this initial experiment was to determine whether the use of hospital swing-beds would help satisfy the demand for long-term care in rural communities and help hospitals manage financial problems arising from excess hospital beds.

Through the years additional swing-bed experiments were initiated and were successful. The favorable results led to Congress enacting swing-bed legislation which was included in the Omnibus Reconciliation Act of 1980. The legislation permitted small rural hospitals to be reimbursed under either Medicare or Medicaid for furnishing long-term nursing services to beneficiaries. As of July 1985, more than one-third of the rural hospitals in the country used swing-beds.

In a report to HCFA, we pointed out that use of swing-beds in small, rural hospitals has proven to be successful in delivering needed long-term care services and that HCFA should consider implementing an experimental strategy to expand the swing-bed option to acute care hospitals regardless of their location or size. Clearly the need for such nationwide expansion exists.

A shortage of nursing home beds is also a nationwide problem. Some leading experts predict that by 1990 there will be a need for more than one-half million additional nursing home beds. This shortage impacts greatly on Medicaid and Medicare patients whose costs of long-term care comprise over 50 percent of our nation's nursing home expenditures.

Conversion of empty hospital beds to swing-beds will enable many patients to gain easier access to long-term care and thus, spare them the trauma associated with what health care professionals term the "no-care zone". This is a term used to describe the plight of patients released from hospitals without prospects of either proper in-home care or adequate nursing home care.

In November 1985, subsequent to the completion of our audit, the Center for Health Services Research, University of Colorado Health Sciences Center, Denver, Colorado issued under a HCFA contract a preliminary report on the use of swing-beds. The Center concluded that "it appears appropriate to give consideration to the use of swing-beds in larger hospitals and hospitals located in urban areas, if only on an experimental basis". The Center recommended that HCFA gear this experiment towards developing alternate reimbursement methods and methods to curb abuse of ancillary charges.

We agree with the Center's observations that swing-beds, like most other health care delivery systems, are vulnerable to abuse. The Center pointed out potential abuse associated with ancillary services. Another and perhaps a more serious abuse relates to premature discharges from acute care to swing-beds. By releasing patients early, hospitals could profit under PPS and receive additional reimbursement for use of swing-beds. Cases of such abuse have been identified at a few problem providers.

Because of this potential for abuse and the possibility of existing control systems being overtaxed, we recommended that HCFA, on an experimental basis, expand use of swing-beds to selected large urban areas. This approach would provide HCFA with a broader base of data on the advantages and disadvantages of widespread use of the swing-bed mechanism.

In summary Mr. Chairman, I would like to end my testimony on a positive note. I believe the Department is now moving ahead in the areas that I have discussed.

MMACS is scheduled to be upgraded and the alternative to nursing home decertification provisions of the Omnibus Reconciliation Act of 1980 should be finalized soon. These actions should put the Department in a much better position to uniformly and consistently identify and deal with substandard nursing homes. Whether or not this will result in a marked decrease in the number of substandard nursing homes participating in Medicaid and Medicare is something that must be closely monitored.

With regard to hospital swing-beds, I am aware that the Department has encouraged use of swing-beds in rural areas and I understand that expanding the swing-bed option to large urban hospitals is under consideration. This concludes my testimony.

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
May 21, 1986

STATEMENT OF

MICHAEL ZIMMERMAN

SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION

FOR THE RECORD

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ON

NURSING HOME STANDARDS ENFORCEMENT

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

We are pleased to discuss our preliminary views on enforcing compliance with nursing home quality of care requirements. At your request, we are reviewing enforcement policies and procedures in five states to determine whether federal and state oversight and enforcement actions are adequate to ensure that nursing homes correct identified deficiencies and comply with federal requirements for participation in Medicare and Medicaid. My comments today are based on preliminary work done primarily in Arkansas and Kansas.

Federal nursing home regulation has three main components: (1) establishing requirements that nursing homes must meet in order to participate in the federal program, (2) inspecting nursing homes to determine compliance with the requirements, and

(3) taking enforcement action when deficiencies are identified. Our work focuses on this third component--the adequacy of enforcement actions.

In brief, our work to date indicates that neither the Health Care Financing Administration (HCFA) nor the two states we visited effectively used existing authority to achieve compliance on a continuing basis with federal nursing home requirements for patient care, health and safety. In both Arkansas and Kansas, nursing homes with a history of deficiencies that jeopardized patient health and safety and/or seriously limited their capacity to provide adequate care were able to remain in the Medicare or Medicaid program by taking corrective action that allowed them to be recertified. These homes, however, were often later found to have the same or similar deficiencies.

We believe that attempts to use "repeat deficiency" regulations (applicable when a requirement not met in the current inspection was also not met in the prior certification period) have been limited by uncertainty and lack of agreement among state and HCFA regional office personnel in interpreting and applying the provisions, such as

--what level of requirements are subject to the repeat deficiency regulations,

--whether actions to enforce the repeat deficiency regulations could withstand the appeals process, and

--whether a state has the authority to decertify a nursing home based solely on repeat deficiencies.

By clarifying policies on repeat deficiencies, placing more emphasis on nursing homes' historical records of compliance, and enforcing the repeat deficiency regulations, HCFA and the states could better assure that nursing homes with substandard conditions comply with federal requirements on a continuing basis.

FEDERAL AND STATE RESPONSIBILITIES IN CERTIFYING NURSING HOMES

To participate in Medicare (a federally administered program) or Medicaid (a federally aided, state-administered program), nursing homes must be inspected and certified at least annually to be in compliance with HCFA's requirements relating to patient care, health, and safety. Facility inspections (i.e., surveys) are made by the state survey agency. As part of the certification process,

- --the state survey agency inspects each nursing home and gives it a written report on requirements not met and related deficiencies;
- --the nursing home prepares a written plan for correcting the deficiencies, including time frames for doing so; and
- --the state evaluates the facility's current and historical deficiencies and plan of correction to determine whether continued certification is justified.

Under HCFA regulations, a nursing home may not be certified as meeting requirements for Medicare or Medicaid participation if (1) it has deficiencies that jeopardize patients' health and safety or seriously limit the home's capacity to provide adequate care (i.e., "current deficiencies") or (2) one or more of the requirements not met were also not met in the prior certification period (i.e., "repeat deficiencies") and were related to conditions the home could control. For the repeat deficiency regulation to apply, the requirement not met must be reported at the standard level, although the state determines skilled nursing homes' compliance with three levels of requirements--conditions of participation (highest), standards, and elements (lowest). For intermediate care facilities, there is one level--standards.

A nursing home with repeat deficiencies may be recertified for Medicare or Medicaid participation if the state documents that the home

--achieved compliance with the standard at some time during the prior certification period,

--made a good faith effort to stay in compliance, and

--again became out of compliance for reasons beyond its control.

Certification of a nursing home with deficiencies is either conditional (with automatic cancellation clauses that must be invoked if adequate, timely corrective action is not taken) or short-term (limited to periods of less than 12 months).

If the state or HCFA determines that a nursing home cannot be certified to be in compliance with federal requirements, only one federal sanction is available under current regulations--terminating participation in Medicare or Medicaid and loss of federal funding. A 30-day extension of federal funding, beyond the effective date of the termination, may be granted in order to give the state time to find alternative care for the affected patients. Furthermore, the nursing home receives a notice of the basis for the termination and may appeal the decision to the Secretary of Health and Human Services or the state (for Medicare or Medicaid certification, respectively).

Although the states make certification decisions in the Medicaid program, HCFA reviews those decisions and can overrule them when it disagrees with the findings or determines that the states did not follow federal regulations and procedures in the inspection or certification process. This review is part of HCFA's oversight program to assure that states are adequately complying with federal policies, procedures, and requirements in making certification decisions. In addition, HCFA makes the final decision in certifying nursing homes' participation in Medicare based on state recommendations.

In fiscal year 1986, the federal government will spend about $650 million in Medicare funds for skilled nursing home care and about $7.2 billion in Medicaid funds for skilled and intermediate nursing home care. The federal government also reimburses the states a portion of their costs to survey and certify nursing homes. In fiscal year 1986, the federal share is estimated to be $55 million.

QUALITY OF CARE PROBLEMS

To determine the significance of reported deficiencies, we reviewed inspection reports and related documents for 10 nursing homes in Arkansas and Kansas that were repeatedly out of compliance with important quality of care requirements. We selected nursing homes that repeatedly did not meet more than one such requirement by (1) reviewing the inspection results contained in HCFA's Medicare/Medicaid Automated Certification System (MMACS) as of November 1985 for all nursing homes participating in Medicare or Medicaid in the two states[1] and (2) asking state or HCFA regional officials to identify problem homes. Because of the method we used to select nursing homes, the 10 homes may not be representative of all nursing homes in Arkansas and Kansas.

Preliminary results from our analysis of inspection reports showed that all 10 nursing homes had recurring quality of care and facility problems. Some deficiencies reflected poor patient care practices. Others, such as inadequate documentation and poorly maintained facilities, affected patients more indirectly. For example, as of November 1985, inspection reports for these homes showed that, in at least two consecutive certification periods,

--patients' feeding or drainage tubes were not properly installed and/or maintained (3 nursing homes);

--unqualified personnel, such as medication aides, installed feeding or drainage tubes (2 homes);

--bedfast patients were not turned or positioned to prevent bedsores (2 homes);

--patients with bladder or bowel control problems were not kept clean and dry (2 homes);

--patient restraints were not periodically released and/or patients were not properly exercised (5 homes);

--patients did not receive needed assistance in eating in a timely manner (3 homes);

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[1] MMACS contains the results of at least the last four inspections for each nursing home.

- --patient records did not show that medications, treatments, or services were provided as ordered (10 homes); and
- --homes did not consistently record information on patients, such as vital signs, food and fluid intake, skin conditions, and diagnostic test results (8 homes).

In addition, the inspections revealed cases of

- --improper food storage (6 nursing homes),
- --inadequate pest control (4 homes), and
- --poor facility maintenance, including inoperative patient call lights, malfunctioning plumbing, broken windows, and damaged floors, ceilings, and walls (10 homes).

All these deficiencies related to requirements that were among those that representatives of organizations involved in nursing home care--including nursing home operators, health professionals, patient advocates, and state licensing officials--told us were most important in ensuring patient care, health, and safety.

LIMITED USE IS MADE OF THE REPEAT DEFICIENCY REGULATION

We also used inspection reports and related documents for these 10 nursing homes to assess the adequacy of federal and state enforcement actions. We found that Arkansas and Kansas generally used the "current deficiencies" provision of the HCFA regulation to take action against the homes when serious deficiencies were identified in an inspection. For example, 3 of the 10 nursing homes were excluded from Medicare or Medicaid for short periods (28 to 76 days) because the identified deficiencies jeopardized patient health and safety and/or seriously limited the homes' capacity to provide adequate care. Each of the homes was later readmitted to the program after corrective actions were taken. The states initiated actions to exclude four other nursing homes under the current deficiencies regulation, but recertified the homes after sufficient actions were taken to correct the deficiencies.

A limitation of the current deficiencies regulation is that a nursing home can comply with federal requirements just long enough to be recertified and then revert to prior substandard conditions until the next inspection. For example, as of November 1985, six of the seven homes discussed above had been inspected since their readmission or recertification. All six homes were found to again be out of compliance with some of the same requirements that had prompted earlier enforcement actions.

Based on our work to date, we believe that special determinations required by repeat deficiency regulations should have been made in conjunction with certification decisions for all 10 nursing homes, in one or more periods. As discussed above, these regulations require a state to determine whether a nursing home that does not meet a requirement at the standard level that was also not met in the prior certification period had achieved compliance with the standard at some point during the prior period, made a good faith effort to stay in compliance, and again became out of compliance for reasons beyond its control before allowing the nursing home to remain in the Medicare or Medicaid program. Of the 10 nursing homes, the determinations were not made for six homes and were not adequate for the remainder.

Our work to date has provided indications of uncertainty and lack of agreement among state and HCFA regional personnel in applying the repeat deficiency regulations. For example, there are differing interpretations as to whether all of the requirements for intermediate care facilities are classified as standards and therefore subject to the repeat deficiency regulations. In addition, an official in Kansas doubted that a facility could be successfully decertified based on repeat deficiencies alone. In his opinion, the state must be able to demonstrate that current deficiencies jeopardize health and safety or seriously limit the facility's capacity to provide adequate care in order to have a case strong enough to withstand appeals. An official in Arkansas believed that only HCFA had the authority to decertify a facility based solely on repeat deficiencies. Officials in both states told us that HCFA had not informed them that their agencies were not complying with the repeat deficiency regulations.

HCFA regional office officials told us that repeat deficiency regulations generally are not being applied by states or by HCFA. While these officials were uncertain as to why these regulations generally are not being applied, they indicated

--it is difficult to make the required determinations,

--decertification actions based on repeat deficiencies alone may not hold up in the appeals process, and

--states are reluctant to use the regulations in instances where there is no significant impact on patient care, health, or safety.

Based on our work to date, it appears that HCFA needs to more clearly enunciate agency policy regarding repeat deficiencies and provide additional guidance and assistance to the states and HCFA regions in interpreting and applying the repeat deficiency regulations.

In conclusion, we believe that it is important to consider nursing homes' historical compliance records in making certification decisions and to take action against homes that have demonstrated an inability or unwillingness to comply with Medicare and Medicaid requirements, especially when there are associated quality of care problems.

Association of Health Facility Licensure and Certification Directors

February 13, 1985

David Shulke, Staff
Special Committee on Aging
United States Senate
Washington, D.C. 20570

Dear Mr. Shulke:

Thank you for attending the recent AHFLCD Board Meeting in Washington, D.C. We appreciated hearing from you regarding Medicaid discrimination and the work of the United States Senate Special Committee on Aging.

Enclosed for your use and information are copies of two final reports on Medicaid discrimination and ownership changes. Recommendations in the reports include:

1. Patient rights be elevated to a condition of participation in the Medicaid program;
2. Federal tax incentives be reviewed relative to encouraging nursing homes to serve Medicaid patients; and
3. Establishment of a federal central clearinghouse with the ability to preclude Medicaid/Medicare program participation to providers with a record of poor patient care.

We welcome your comments on the reports and would be happy to answer further questions you might have.

On behalf of the Association, thank you and the committee for your dedicated work regarding the health care needs of the elderly.

Sincerely,

Louis E. Remily, President

LER:CT:mw

Enclosures: Medicaid discrimination report
Ownership change report

cc: Conrad Thompson
AHFLCD Board Members

Association of Health Facility Licensure and Certification Directors

MEDICAID DISCRIMINATION

Interstate Survey

Association of Licensure and Certification Directors

Louis E. Remily, President

January 1985

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Acknowledgements

We would like to thank the states that furnished the information for this report. David McKee from the State of Washington, had primary responsibility for compiling and analyzing the data and writing the final report. Acknowledgement is also extended to the following members of the Issues Committee:

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Association of Health Facility Licensure and Certification Directors

Issues Committee
January 25, 1985

MEDICAID DISCRIMINATION

Final Findings of Interstate Survey

BACKGROUND

"Medicaid Discrimination" is a term used to describe instances in which individuals eligible for Medicaid:

- are denied admission to nursing homes solely because of their economic status.
- are transferred out of a nursing home and not allowed to return when they convert from private pay status to Medicaid.
- are transferred to another nursing home in order to make room for a private paying patient.
- are denied readmission to a nursing home following hospitalization.
- are moved to less desirable sections of nursing homes.

Medicaid Discrimination is an issue of increasing concern to a number of states. It was recently the subject of review by Senator John Heinz's Special Committee on Aging. The Association of Health Facility Licensure and Certification Directors is actively reviewing this matter.

In order to gather more information on Medicaid Discrimination, a questionnaire was developed by the Issues Committee to survey the extent of the problem and possible solutions. The questionnaire was approved by the Board of the Association in August, 1984, at their meeting in Seattle, and mailed to the licensure and certification directors in each state and the District of Columbia. A total of 38 responses were received and form the basis of this report.

In reflecting upon this data, it is important to recognize the limitations:

- many states reported that no formal records were kept regarding this problem, and thus, their responses were rather subjective. Some states reporting an absence of Medicaid Discrimination may be less sensitive to its occurrence than states reporting the problem.

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- many states did not rank order the multiple sanctions reported for Medicaid Discrimination. Summary data does not differentiate between most frequently used sanctions and less frequently used sanctions.

- the questionnaire did not address the frequency with which any sanctions were attempted, nor the ultimate successfulness of actually imposing the sanctions. Thus, it is not known whether or not the sanctions reported are in fact viable options for the agencies.

- many states did not rank order other reported factors which may minimize the incidence of Medicaid Discrimination. Thus, no distinction is made in the summary data between very significant and less significant minimizing factors.

FINDINGS

The results of this survey are as follows:

- Thirteen out of 38 respondents reported that Medicaid Discrimination is a problem.

- Twenty-five out of 38 respondents reported that Medicaid Discrimination is not a problem in their state.

- Eight out of 13 states reporting that Medicaid Discrimination is a problem indicated the trend of discriminatory practices is increasing. None of the states reporting discrimination is not a problem thought the trend was increasing.

- The incidence of discrimination formally reported is quite low, i.e., seldom more than three complaints per month. The actual incidence is considered much higher.

- States reporting problems with Medicaid Discrimination appeared generally to have more sanctions available to deal with the problem than states reporting an absence of Medicaid Discrimination. For example, 54 percent of the states reporting discriminatory practices indicated civil fines are a possible sanction, compared to only 12 percent of the states reporting no problems with Medicaid Discrimination. The following table summarizes these findings:

Sanctions Available	Percent of States Reporting Medicaid Discrimination is a Problem with Sanctions Available N=13	Percent of States Reporting Discrimination is not a Problem with Sanctions Available N=25
Civil Fines	54 percent	12 percent
Criminal Prosecution	0	8
Letters from Survey Agency	62 percent	44 percent
Terminate Contract	31 percent	52 percent
Civil Suits by Patient	38 percent	24 percent

- The following responded that Medicaid Discrimination is a problem in their state: California, Connecticut, Kentucky, Iowa, Michigan, Minnesota, Nevada, New Jersey, New York, Ohio, Oregon, South Carolina, and Washington. Of these, Connecticut, Iowa, Michigan, Minnesota, Oregon, New Jersey and New York reported that they are able to impose civil fines for providers engaging in some type of Medicaid Discrimination. Most commonly, fines can be imposed for transferring patients when they convert from private pay to Medicaid, or for basing transfer decisions on the source of payment.

- Three factors minimizing the incidence of Medicaid Discrimination are predominant in states reporting no problems with Medicaid Discrimination. Those factors are:

  - There are significant numbers of available nursing home beds, eliminating the competition between private pay and Medicaid patients, i.e., bed utilization is lower.

  - The Medicaid contract specifically prohibits discrimination based upon a patient's economic status.

  - The Medicaid rates are considered adequate.

The following table summarizes the differences in minimizing factors between states experiencing and not experiencing Medicaid Discrimination.

Factors Minimizing Medicaid Discrimination	Percent of States Reporting Medicaid Discrimination is a Problem with Minimizing Factor N=13	Percent of States Reporting Discrimination is not a Problem with Minimizing Factor N=25
Contract Prohibits	23 percent	56 percent
State Rules/Regulations	69 percent	44 percent
State Statutes Prohibit	38 percent	40 percent
Adequate Number of Beds	23 percent	72 percent
Private Rates Controlled	8 percent	0
Ratios/Quotas Required	15 percent	0
Adequate Medicaid Rates	15 percent	56 percent

- New Jersey and Ohio reported they require Medicaid providers to maintain a specified ratio or quota of Medicaid patients in their facilities. Minnesota reported it has put limitations on private rates. Connecticut, Iowa, Michigan, Minnesota and Ohio reported they have state statutes prohibiting Medicaid Discrimination. Connecticut, Ohio and Washington have Medicaid contracts which require providers to accept Medicaid patients.

- One other minimizing factor reported in narratives on the returned questionnaires is a very high percentage of Medicaid patients in two states. In those states, there are relatively few private paying patients competing for available beds. Thus, nursing homes are willing to accept Medicaid patients.

- The questionnaire did not inquire into the existence of states requiring providers to place all applicants for admission on one waiting list, from which all admissions must be made in order of application. Thus, no data was collected on this means of controlling discriminary practices. However, Connecticut reported it has recently passed a law requiring a single waiting list.

In summary, having more sanctions available may not necessarily prevent the practice of Medicaid Discrimination. However, this survey did not assess the viability of the reported sanctions. Other factors generally appear to contribute more to preventing discriminatory practices: specifically, having an adequate supply of beds, having an adequate Medicaid rate and prohibiting discrimination in the Medicaid contract. The individual state's responses are recorded on the attached tables.

For background on issues involved in Medicaid Discrimination, but not addressed in the survey, Attachment 1 presents a copy of a letter to Senator Heinz from Conrad Thompson of the State of Washington. The letter discusses, e.g., problems with identifying the incidence of Medicaid Discrimination, problems with lack of clarity of the federal position on discrimination, and some suggestions for federal action. Attachment 2 is a letter from federal officials to our Association President that implies Medicaid Discrimination in initial admissions is not a violation of federal law. Attachment 3 is a copy of anti-discrimination legislation that the State of Washington is introducing into their 1985 legislative session.

STATE OPTIONS

In addition to the recommendation for state legislation, four possible options should be considered by states with identified problems of Medicaid Discrimination. It is recognized there are potential difficulties with any of these options:

1. Control or limit the rates charged to private paying patients to eliminate or minimize the increased profitability of admitting private patients instead of Medicaid patients.
2. Require each nursing home to have only one waiting list, regardless of payment source, for persons requesting admission. Require that all admissions be made from this waiting list, in the order of the date of application. Exceptions should be made explicit, e.g., a patient discharged to a hospital and subsequently seeking readmission to the same nursing home. This is a new and untried approach that may entail major administrative and programmatic problems.
3. Require nursing homes to maintain a certain quota or ratio of Medicaid patients.
4. Give priority in the Certificate of Need approval process to applicants who indicate a commitment to serving the Medicaid population or have a demonstrated history of services to Medicaid patients.

RECOMMENDATIONS

1. That this report, after acceptance by the Board of the Association, be distributed immediately to all state certification directors and other interested parties. The

report should be useful to states during their present legislative sessions and provide a helpful networking tool for states and others that wish to pursue further action on the Medicaid Discrimination issue.

2. That the Association continue to urge the Health Care Financing Administration (HCFA) to clarify the federal position on Medicaid Discrimination and, if necessary, to request congressional action to clarify the federal stance. Attachment 1 provides background on the issue of uncertainty of the present federal statutes prohibiting discrimination. Attachment 2 is a federal letter to the Association President, which seems to clearly indicate discrimination in initial admissions is legal and encourages states to pass their own statutes.

3. That states seriously consider implementing statutes to prohibit discrimination and permit intermediate sanctions, such as civil fines, for violations. Even those states not presently identifying they have a Medicaid Discrimination problem should consider this action in light of the uncertainty of the federal statutes, which most states have relied on. The federal government has clearly indicated that they would recognize state laws prohibiting discrmination. See Attachment 3 for an illustrative state statute.

4. That individual states forward court cases regarding Medicaid Discrimination to Conrad Thompson, Chair of the Issues Committee. Conrad will ensure that cases received will be distributed to all the states to ensure that they can keep up to date on the complex legal issues surrounding Medicaid Discrimination.

5. That the Association encourage the Institute of Medicine, in their review of the discrimination issue, to consider recommending federal tax incentives or penalties which would encourage nursing homes to serve Medicaid patients. Also, that the Association support such recommendations, if included in the Institute's report to Congress.

6. That this report be shared with appropriate officials in HHS and in the U.S. Congress, with an invitation to review and comment on the report.

7. That patient rights be elevated to a condition of participation in the Medicaid program.

STATE	PROBLEM IDENTIFICATION (1)						AGENCY RESPONSIBLE FOR INVESTIGATING COMPLAINTS (2)						SANCTIONS (3)						MINIMIZING FACTORS (4)								HOSPITAL BACKUP (5)			
	1.a Is Medicaid Discrimination A Problem	1.b Is Medicaid Discrimination A Potential Problem	1.c # Complaints Per Month Of Denied Admissions	1.c # Complaints Per Month Of Transferring Out	1.c # Complaints Per Month Of Transferring Within	1.c Is The Trend Increasing	State Survey Agency	Local Medicaid/ Social Serv. Office	State Attorney General	Ombudsman	Local Prosecuting Attorney	Other	3.a Civil Fines Or Penalties	3.b Criminal Prosecution	3.c Letters From Survey Agency	3.d Terminate Medicaid Contract	3.e Civil Suits By Patients	3.f Other	4.a Medicaid Contract	4.b State Regulations	4.c State Statutes	4.d Adequate # Beds	4.e Control Private Rates	4.f Required Ratios	4.h Adequate Medicaid Rates	4.i Other	Occasional Problem	Frequent Problem	Serious Problem	No Problem
California	YES																											X		
Connecticut	YES		1-3	1-3	<1			X		X			X				X		X	X	X								X	
Iowa	YES						X						X							X	X	X					X			
Kentucky	YES	YES				YES	X	X	X	X	X	X			X	X	X			X								X		
Michigan	YES		1-3	4-10	4-10	YES	X			X			X		X					X	X					X		X		
Minnesota	YES		1-3		1-3	YES	X			X		X	X		X	X	X			X	X		X							X
Nevada	YES	YES	<1	1-3	<1	YES		X				X						X				X			X		X			
New Jersey	YES		1-3	1	<1	NO	X	X		X			X		X					X				X				X		
New York	YES		1-3	1-3	<1	NO	X			X			X		X					X								X		
Ohio	YES			4-10		YES	X	X	X	X	X					X	X	X	X	X	X			X				X		
Oregon	YES		Frequent	Frequent		YES	X	X					X		X			X		X		X			X		X			
South Carolina	YES		11-20	1-3		YES	X	X		X					X														X	
Washington	YES	YES	<1	<1	<1	YES	X			X	X				X	X	X		X									X		

STATE	PROBLEM IDENTIFICATION (1)						AGENCY RESPONSIBLE FOR INVESTIGATING COMPLAINTS (2)						SANCTIONS (3)						MINIMIZING FACTORS (4)								HOSPITAL BACKUP (5)			
	1.a Is Medicaid Discrimination A Problem	1.b Is Medicaid Discrimination A Potential Problem	1.c # Complaints Per Month Of Denied Admissions	1.c # Complaints Per Month Of Transferring Out	1.c # Complaints Per Month Of Transferring Within	1.c Is The Trend Increasing	State Survey Agency	Local Medicaid/ Social Serv. Office	State Attorney General	Ombudsman	Local Prosecuting Attorney	Other	3.a Civil Fines Or Penalties	3.b Criminal Prosecution	3.c Letters From Survey Agency	3.d Terminate Medicaid Contract	3.e Civil Suits By Patients	3.f Other	4.a Medicaid Contract	4.b State Regulations	4.c State Statutes	4.d Adequate # Bed's	4.e Control Private Rates	4.f Required Ratios	4.h Adequate Medicaid Rates	4.i Other	Occasional Problem	Frequent Problem	Serious Problem	No Problem
Alabama	No	No	<1	1-3	<1	No	X	X														X			X		X			
Alaska	No	No	<1	<1	<1		X			X									X	X	X	X			X					X
Arizona	No																													
Arkansas	No	No	<1	<1	1-3	No	X								X	X		X	X	X		X			X					X
Colorado	No	Yes	<1	<1	<1		X		X	X				X	X					X		X			X					X
Delaware	No	No	<1	<1	<1	No	X	X		X							X			X	X	X					X			
District of Columbia	No	No	<1	<1	<1	No	X	X		X	X				X							X					X			
Florida	No		<1	<1	<1	No	X	X		X			X								X	X					X			
Hawaii	No	Yes	<1	<1	<1	No	X	X		X					X	X			X										X	
Idaho	No	Yes	<1	<1	<1	No	X	X		X					X							X			X					X
Maine	No	No		<1		No	X			X					X												X			
Missouri	No		<1	<1	<1		X	X				X			X	X			X	X	X	X			X					X
Montana	No	Yes	<1	<1	<1	No				X					X	X			X			X			X		X			
Nebraska	No							X														X					X			
New Mexico	No	Yes	<1	<1	<1	No		X		X						X	X		X	X	X				X					X
North Carolina	No	No	<1	<1	<1	No	X	X	X				X		X	X			X	X	X	X			X					X
North Dakota	No																													
Rhode Island	No	No	<1	<1	<1	No		X								X			X		X				X		X			
South Dakota	No	Yes	<1	<1	<1	No		X				X				X	X	X	X			X			X		X			
Texas	No	No	<1	<1	<1		X					X				X			X	X		X			X		X			
Utah	No	No	<1	<1	<1	No	X			X						X		X				X								X
Vermont	No	Yes	<1	<1	<1	No	X	X	X					X		X	X		X	X	X						X			
Virginia	No	Yes	<1	<1	<1	No	X	X	X	X	X	X				X	X	X	X	X	X	X			X		X			
Wisconsin	No	Yes					X	X	X	X	X		X		X				X	X	X	X								X
Wyoming	No	No	<1	<1	<1	No	X	X		X					X	X	X		X			X			X		X			

JOHN SPELLMAN
Governor

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia Washington 98504

ATTACHMENT 1

November 21, 1984

The Honorable John Heinz, Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

This letter responds to your inquiry regarding Washington State's experiences in dealing with discrimination against Medicaid recipients in nursing homes. In addition to the types of discrimination identified in your letter, Medicaid discrimination also occurs when individuals eligible for Medicaid:

- are transferred out of a nursing home when they convert from private pay status to Medicaid.
- are transferred to another nursing home in order to make room for a private paying patient.
- are denied readmission to a nursing home following hospitalization, solely because of their Medicaid status.
- are moved to less desirable sections of nursing homes after converting to Medicaid.

Washington's Bureau of Nursing Home Affairs is interested in ways to ensure the the rights of Medicaid patients seeking admission to and receiving nursing home care. We appreciate your leadership in protecting the fundamental civil rights of Medicaid recipients. For your convenience, the questions raised are addressed in the order they appear in your request.

(a) "How prevalent is Medicaid discrimination?"

An accurate account of the extent of Medicaid discrimination is difficult to obtain. First, there is no federal policy or accepted criteria for defining when Medicaid discrimination actually occurs. Medicaid discrimination should refer to any action on the part of a Medicaid certified nursing home which treats Medicaid patients differently than other patients, solely because of their Medicaid status. The present Social Security Act definition of discrimination is restricted to a nursing home demanding additional payment on behalf of a patient or as a condition for admission to a home. This definition is too narrow.

Second, Medicaid discrimination is difficult to prove. Often, Medicaid applicants and recipients are not aware they have been discriminated against. They simply are told no vacant bed is available or that they must relocate to another home. Also, the issue of heavier care needs, and whether or not a particular home at a particular time can appropriately meet a patient's needs, can confound the question of whether discrimination in fact has occurred. Patients and their families or friends typically find it very difficult to protect their civil rights.

For example, if a provider has admitted four Medicaid recipients consecutively, and chooses to admit a private paying patient over a Medicaid eligible patient, can it be said that the provider engaged in discriminatory practices? Should a patient's degree of medical need be considered in determining nursing home admission priorities; e.g., should the most disabled be given priority regardless of the source of payment? What priority should be established for readmitting a patient to a nursing home who required hospitalization?

Third, a high occupancy rate overall makes it difficult to place all patients, Medicare, Medicaid and private. As the elderly population increases, it is probable the bed supply will tighten and overall admission problems will intensify. Private patients also need nursing home services. Preliminary evidence nationally and in our state indicates private patients are at least as debilitated as Medicaid, perhaps more so. The burden of high private rates, perhaps $2,000 to $3,000 per month, which falls entirely on the patient or family, is a strong disincentive to admit a private patient until absolutely necessary. If sufficient beds are not available, the problem of discrimination cannot be dealt with effectively.

The number of reports of discrimination are probably not an accurate reflection of the scope of the problem. This opinion is based upon discussions with attorneys who have represented elderly persons seeking admissions to nursing homes, reports received from local Community Services Offices who assist in placing eligible patients and hospital discharge planners. Washington has received about one "official" complaint a month over the last six months, mostly from legal services attorneys.

(b) "How common is it for a nursing home resident, whose care is initially financed privately, to expend her/his assets and subsequently become reliant upon Medicaid?"

(c) "How much time elapes between the admission of an average privately-financed nursing home resident and the point at which s/he becomes Medicaid eligible?"

The average number of patients residing daily in Washington's nursing homes (excluding residential facilities for the developmentally disabled) is 25,300 with a 95 percent occupancy rate. The Medicaid patient population is 15,430, or 61 percent of the total. Private paying patients comprise approximately 32 percent of the total nursing home population and Medicare patients approximately three percent.

Out of the population of patients who became Medicaid eligible in 1983, 30 percent were in the nursing home for over one month before becoming Medicaid eligible. For the 30 percent who initially had alternate sources of payment, the average length of stay in a nursing home before converting to Medicaid funding was 382 days.

(d) "Do nursing home providers in your State refuse to process paperwork necessary for a resident or prospective resident to become Medicaid eligible (particularly where a person would only be eligible if classified as "medically needy")?"

Generally, nursing homes facilitate the process of patients making an application for Medicaid. The providers' official role is one of helping the patient obtain the necessary forms. The application itself is prepared by the patient, family or friends and sent to the local Community Services Office (CSO) of the Department of Social and Health Services. Nursing home staff or other interested parties sometimes assist in preparing the application. The application is processed and eligibility determined in the CSO. Nursing homes are guaranteed that they will receive reimbursement from the state for any nursing home resident placed by the state prior to the actual final determination of eligibility for Medicaid. This helps to lessen the nursing homes' resistance to accepting Medicaid patients prior to their eligibility determination being finalized.

For private paying patients already in the nursing home, about to exhaust their personal resources, it is to the providers' advantage to help establish eligibility. This can avoid a gap in payments between the exhaustion of private resources and the commencement of Medicaid payments. We are not aware that homes treat "medically needy" patients different than other Medicaid patients. This may be related to Washington State's general policy of paying for all patients with income below the private payment rate for the facility.

(e) "Do providers refuse to accept Medicaid payments made on behalf of nursing home residents retroactively determined to be eligible?"

Eligibility is made retroactive to the date of application for Medicaid, if all eligibility conditions are met. There have been reports of providers refusing to refund private payments made for Medicaid patients while their Medicaid eligibility was being determined. The Bureau of Nursing Home Affairs is in the process of sending a letter (Attachment 1) to all nursing homes advising them they may require private payments for nursing home patients pending an eligibility determination. However, all private payments received for a time period subsequently determined to be covered by Medicaid eligiblity must be refunded by the provider.

(f) "Is criminal prosecution of providers who engage in these practices a viable option for your State?"

(g) "Are your State's administrative sanctions effective in deterring provider practices such as those listed above? (Please describe why sanctions are/are not effective at present.)"

The absence of clear federal criteria pertaining to Medicaid discrimination, the criminal law burden of proof "beyond the shadow of a doubt," and prosecution costs, result in criminal prosecution in Washington State not being a viable option. Currently, the only actual sanction that is available is the termination of the provider's Medicaid contract. If this occurred, it would require relocating all of the Medicaid patients in the facility. On the average, 60 patients out of a 100 bed nursing home would require relocation. Ultimately the Medicaid patients suffer as a result of the contract cancellation. To help address this problem, the Department of Social and Health Services intends to introduce legislation into the 1985 Legislative Session to authorize the imposition of civil fines if an individual's Medicaid status is considered in admission decisions. A copy of the draft bill is attached for your reference (Attachment 2).

Presently, when a complaint of Medicaid discrimination is received, the Bureau seeks to determine the facts of the complaint. That information is forwarded to a state assistant attorney general, who determines if the county prosecuting attorney should be involved. A letter is sent to the provider advising them of the report and seeking any further information. If there are sufficient reasons and available evidence, the matter would be referred to the prosecuting attorney for criminal prosecution. The long-term care ombudsman may also be contacted to advocate for the patient, or the Medicaid patient may also file a civil suit, although the chances of a successful suit are extremely limited for the reasons previously discussed; i.e., lack of definition, hard to prove and lack of adequate intermediate sanctions.

(h) "Is the Federal Government doing all it can to curtail these practices?"

No. The Federal Government should better define Medicaid discrimination, establish criteria to be used to determine when it occurs, and empower states to take action to prevent Medicaid discrimination through intermediate sanctions to be developed at the federal level. In the case of (i) below, whatever you could do to encourage HCFA to quickly clarify the federal position on the existing discrimination statute would be much appreciated.

(i) What has been the Secretary's response to State agency requests for a firmer DHHS policy in this area?

In November 1983, Region X of HCFA sent out State Agency Letter No. 84-02 regarding "Freedom of Choice" for long-term care providers. This letter appears to permit a provider to legally refuse to admit a Medicaid patient in need of nursing home care, simply by not, "undertaking to provide him such services, i.e., is not willing to do so." The four states of Region X, Washington, Oregon, Alaska, and Idaho, took exception to this policy and have gone on record to seek clarification from the director of Region X by way of letter dated December 9, 1983.

In January 1984, notice was received from Region X that this policy was being discussed in HCFA's Central Office. In the absence of receiving further clarification, reminder letters were sent to Region X on April 3, 1984 and August 6, 1984. On October 1, 1984, notice was received that the question is still being discussed and an answer could be expected within 45 days. (Attachment 3) The president of the Executive Board of the Association of Health Facility Licensure and Certification Directors has also sought clarification of federal policy from Margaret Heckler, Secretary of DHHS, in a letter dated November 14, 1984. (Attachment 4)

(j) "Please share your suggestions for national legislative reform that may be effective in curbing provider abuses of aged Americans' right of access to nursing home services."

Washington's Bureau of Nursing Home Affairs is coordinating a national survey regarding Medicaid discrimination. This survey is sponsored by the Association of Health Facility Licensure and Certification Directors. Some preliminary observations are:

- States with lower utilization rates of nursing home beds do not appear to be experiencing Medicaid discrimination. The number of beds relative to the population is not the key variable. It is the use rate of the beds available that appears critical.

- States with a high nursing home occupancy rate experience greater problems with Medicaid discrimination. These states also have more sanctions to combat the problem, although no state appears to have highly effective sanction systems.

- Criminal prosecution does not appear effective in preventing discrimination. Discrimination is difficult to prove, particularly in a criminal suit, and prosecution is costly. Civil fines administratively imposed by the state regulatory agency may be more effective.

- Medicaid discrimination appears to be less of a problem in two states with a very high percentage of Medicaid patients and few private paying patients. Providers apparently cannot afford to refuse Medicaid admissions when so few private paying applicants are available.

It is our understanding that Connecticut recently passed Public Act No. 84-245 which requires nursing homes to place each applicant who requests placement on a waiting list and provide a receipt stating the date and time the request was made. Medicaid patients would then be admitted from the list as vacancies occur, in the same manner as private pay patients.

We have not had an opportunity to review this law in detail. The concept of each nursing home having one waiting list from which all admissions must be made in order of application is untested. Administrative issues and exceptions; e.g., hospital readmissions and priority for more disabled patients,need further review.

On a national level, consideration might be given to providing increased federal income tax advantages to nursing homes serving significant numbers of Medicaid patients. For example, if the state-wide average percentage of Medicaid patients in nursing homes is 60 percent, extra tax advantages could be structured for nursing homes at or above 60 percent Medicaid occupancy. With favorable tax treatment, the financial incentives to choose to admit private paying patients would be diminished.

In considering a favorable tax structure, Medicaid discrimination is not limited to for-profit facilities. It also is a problem in non-profit nursing homes as well. The tax advantages may not be as applicable to non-profit facilities. However, consideration could also be given to diminishing the present tax exemptions for non-profit facilities if they failed to maintain a reasonable percentage of Medicaid patients.

Washington State remains committed to the ideal that Medicaid patients should have equal access to nursing home resources. Society - government - has an obligation to help protect the legal rights of this most vulnerable and defenseless group of citizens. We would greatly appreciate a copy of any reports issued as a result of your inquiry into this important matter.

If we may be of further assistance, please call (206) 753-5840.

Yours truly,

Conrad Thompson

Conrad Thompson, Director
Bureau of Nursing Home Affairs 08-31

CT:ba

cc: Jerry Reilly
Carole Washburn

Attachments: 1) BNHA Letter 1184-1

2) Draft Medicaid Discrimination Bill

3) State Agency Letter 84-02
Reilly Letter to Anderson, 12/9/83
Anderson Letter to Reilly, 1/12/84
Reilly Letter to Anderson, 4/3/84
Reilly Letter to Anderson, 8/6/84
Anderson Letter to Reilly, 9/27/84

4) Remily Letter to Heckler 11/14/84

JOHN SPELLMAN
Governor

KAREN R
Secreta

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

November 26, 1984

BNHA 1184-1

DRAFT

Dear Nursing Home Administrator.

This letter serves to describe changes in initial Medicaid financial eligibility determinations.

In the past, any private payments made for a patient's nursing home care were considered a resource available to the patient. This affected the date the patient became Medicaid eligible. For example, a patient would apply for Medicaid and the patient or relative would pay at the private rate until eligibility was determined. The date of Medicaid eligibility was affected as the money being paid was considered a resource that had to be expended for the patient's care, before Medicaid payments could begin.

The Department of Social and Health Services has adopted a new policy. During the month application is made for Medicaid, private payments made on behalf of a patient no longer affect the determination of the date of eligibility. Medicaid funds are available from the first day of the month for which the Medicaid applicant is determined eligible.

Nursing homes must accept the Medicaid payment rate as "payment in full." Any private payment accepted for the month of application or thereafter must be refunded by the provider to the payer. The department is billed at the Medicaid rate, once the applicant is determined eligible. Federal and state laws prohibit nursing homes from requiring nonrefundable private payment from persons who are filing applications for Medicaid and are subsequently determined eligible. Attached for your information is an opinion of an Assistant Attorney General regarding refunding private payments.

If the applicant has pre-paid the facility for the month of application or thereafter, the prepayment is considered an available resource and may affect eligibility. Eligibility is determined by the total resources available to the applicant during the month of application. Final eligibility determinations are made by the local Community Services Office.

Contractors providing care to person eligible and potentially eligible for Medicaid are expected to provide assistance in establishing eligibility in coordination with the nearest Community Services Office. If you have any questions regarding eligibility, please call the Community Services Office in you area.

Sincerely,

Gerald Reilly, Director
Division of Medical Assistance

CT:jl

Enclosure: AAG Opinion of July 6, 1984

RECEIVED
JUL 10 1984
DSHS - BNHA OB-31
[illegible]

OFFICE OF THE ATTORNEY GENERAL

Inter-office Correspondence Date: July 6, 1984

To: Darlene Aanderud, Manager
Program Integrity Unit, BNHA, OB-31
From: ATM Allen T. Miller, Jr.
Assistant Attorney General, PY-13
Subject: MEDICAID PAYMENT AS PAYMENT IN FULL FOR MEDICAID SERVICES FROM THE EFFECTIVE DATE OF ELIGIBILITY FOR MEDICAID

You have solicited my opinion vis-a-vis several questions dealing with the above-referenced subject. First, you asked me whether there is legal authority to require refunding of private payments retroactive to the first day of the month in which Medicaid eligibility was determined. I believe there is such authority stemming from the fact that under both federal and state law, Medicaid payments are payment in full for those services provided by Medicaid, and that eligibility for medical assistance payments becomes effective on the first day of the month in which an individual is found to be eligible for medical assistance.

Both 42 U.S.C. § 1396h(d)(1) and RCW 74.09.260(1) provide that it is a felony for a contractor to charge or receive excessive payments beyond the Medicaid rate established for Medicaid services. The Medicaid contract states: "The Contractor shall not charge or accept additional remuneration from any recipient . . . or any other person for services provided under this agreement . . ." 42 C.F.R. § 447.15 also provides: "A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency."

The Medicaid provider contract and the laws clearly require that the provider must accept Medicaid payments as payment in full for any Medicaid services provided, and the provider may not charge an extra fee for such services. Thus, once a nursing home patient becomes eligible for Medicaid and medical assistance payments are made for services provided, any payments that the patient may have paid for those services must be refunded. Otherwise, the provider would be receiving payment for services that are paid through medical assistance.

WAC 388-84-115 states that the effective date of eligibility for medical assistance is the first day of the month in which the individual was eligible at any time during the month.

Thus, if a person applies for and is declared eligible for medical assistance on March 31, he is eligible for Medicaid effective March 1. Any payments the individual may have made for services beginning on March 1 and thereafter must be refunded by the nursing home contractor since medical assistance will pay for those services.

The second inquiry is, When do the sanctions under RCW 74.09 .260(2) for soliciting private payment apply? The provider would violate the statute the first day of the month in which the Medicaid patient's eligibility becomes effective and Medicaid begins to flow.

RCW 74.09.260(2) provides that:

> Any person, including any corporation, that knowingly
>
> (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under such plan any gift, money, donation, or other consideration . . .
>
> (a) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
>
> (b) as a requirement for the patient's continued stay in such facility,
>
> when the cost of the services provided therein to the patient is paid for, in whole or in part, under such plan, shall be guilty of a class C felony . . .

This statute provides that an individual who is eligible for medical assistance, or his relatives, cannot be required to sign an agreement which compels payment as a private patient as a condition for entering or staying in the nursing home. As seen above, under WAC 388-84-115, an individual is eligible for medical assistance effective on the first day of the month in which the individual is declared eligible. Thus, the sanctions for soliciting private payment under the statute would apply on the first day of the month in which an individual is eligible and medical assistance payments are made.

Finally, you have asked me under what circumstances would a provider be guilty of soliciting private payment from an eligible Medicaid assistance recipient. The term "solicit" is defined in Black's Law Dictionary (5th ed.) as:

> To appeal for something; to apply to for obtaining something; to ask earnestly; to ask for the purpose of receiving; to endeavor to obtain by asking or pleading; to entreat, implore, or importune; to make petition to; to plead for; to try to obtain; and though the word implies a serious request, it requires no particular degree of importunity, entreaty, imploration, or supplication.

The term implies a personal petition and importunity addressed to a particular individual to do some particular thing. Thus, a provider would be guilty of soliciting private payment from a medical assistance recipient when the nursing home asks for a payment from a person who is eligible to receive medical assistance payments under WAC 388-84-115. Once the services rendered to a patient are being paid for through medical assistance, the provider may not ask the patient to pay for those services.

The addressee is reminded that this memorandum is the opinion of the author and is not to be construed as an official Attorney General's opinion.

ATM:sh

cc: Peggy Brown

Association of Health Facility Licensure and Certification Directors

ATTACHMENT 2

January 4, 1985

JAN 11 1985

Conrad Thompson, Director
Bureau of Nursing Home Affairs
OB-31
Olympia WA 98501

Dear Conrad:

Attached is a response from Thomas G. Morford to the November 14, 1984 letter you authored for my signature regarding Medicaid discrimination.

Upon receipt of additional information, I will pass that along as well. At that time the Issues Committee can review the response to determine what, if any, further action is needed.

It appears that the Heckler letter was timely and unless there is legislation at the federal level, each state will have to pass their own non-discrimination laws as they may choose.

Sincerely,

Louis E. Remily, President

Deputy Director
Bureau of Quality Compliance
Division of Health
P.O. Box 309
Madison WI 53701

LER:jmb
enc.
cc: Executive Board
Issues Committee
George Degnon, ASTHO
Thomas Vernon, M.D.

monitoring the health care of a nation

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Health Standards and Quality Bureau
1849 Gwynn Oak Avenue
Baltimore, Maryland 21207

DEC 21 1984

Mr. Louis E. Remily
Deputy Director
Bureau of Quality Compliance
Wisconsin Division of Health
P.O. Box 309
Madison, Wisconsin 53701

[illegible]
1984
Bureau of Quality Compliance
[illegible]

Dear Mr. Remily:

This is in response to your letter of November 14 to Secretary Heckler. I am responding because the Health Standards and Quality Bureau is responsible for overseeing the enforcement of Federal requirements in certified nursing homes.

I will provide you a detailed response to each of the issues you raised in the near future. However, in the interim, I would like to make particular note of the following major points.

First, I assure you the Health Care Financing Administration (HCFA) and, indeed the entire Department of Health and Human Services, in no way condones discrimination in the Medicaid (or any other) program. I am the HCFA representative on the Under Secretary's Working Group on Discrimination. This group was formed to advise the Under Secretary on the nature and scope of discrimination and to recommend possible remedies based upon the answers found to the nature and scope issue. We are examining the questions you raised in your letter as well as further issues.

The second point deals with the Social Security Act as it relates to the rights of patients and facilities. A nursing home which is certified to participate in Medicaid has no obligation under Federal law to admit a Medicaid eligible patient. Therefore, unless prohibited by State law, a facility may, indeed, deny an admission to a Medicaid eligible individual if they do not want to take any more Medicaid patients. It is also important to note that if an individual admitted to a Medicaid certified facility as a private pay patient becomes Medicaid eligible the facility may not discharge the patient because he is now a Medicaid patient.

I hope the above information clarifies some of the relevant Federal laws and requirements. As I noted, I will respond to your other issues at a later time.

If you have any further questions, please contact me.

Sincerely yours,

Thomas G. Morford
Deputy Director

ATTACHMENT 3

WASHINGTON STATE BUREAU OF NURSING HOME AFFAIRS

PROPOSED STATUTE ON MEDICAID DISCRIMINATION

NEW SECTION. Sec. 3. A new section is added to chapter 74.42 RCW to read as follows:

(1) The purpose of this section is to prohibit discrimination against medicaid recipients by nursing homes which have contracted with the department to provide skilled or intermediate nursing care services to medicaid recipients.

(2) It shall be unlawful for any nursing home which has a medicaid contract with the department:

(a) To require, as a condition of admission, assurance from the patient or any other person that the patient is not eligible or will not apply for medicaid;

(b) To deny or delay admission or readmission of a person to a nursing home because of his or her status as a medicaid recipient;

(c) To transfer a patient, except from a private room to another room within the nursing home, because of his or her status as a medicaid recipient;

(d) To transfer a patient to another nursing home because of his or her status as a medicaid recipient;

(e) To discharge a patient from a nursing home because of his or her status as a medicaid recipient.

(3) The department may assess monetary penalties of a civil nature, not to exceed one thousand dollars for each violation of this section.

(4) Because it is a matter of great public importance to protect senior citizens who need medicaid services from discriminatory treatment in obtaining long-term health care, any violation of this section shall be construed for purposes of the application of the consumer protection act, chapter 19.86 RCW, to constitute an unfair or deceptive act or practice of unfair method of competition in the conduct of trade or commerce.

Association of Health Facility Licensure and Certification Directors

NURSING HOME AND HOSPITAL OWNERSHIP CHANGES

Interstate Survey

Association of Licensure and Certification Directors

Louis E. Remily, President

January 1985

monitoring the health care of a nation

Acknowledgements

Special recognition goes to the states that contributed information for this report. Denise Hanna, from the State of Washington, was instrumental in analyzing the data and writing the final report. Thanks also due to Evonne Peryea who compiled the data. Acknowledgement is also extended to the following members of the Issues Committee:

1984 Issues Committee	1985 Issues Committee	State	Telephone No.
Conrad Thompson	Conrad Thompson	Washington	(206) 753-5840
John Jarrell	Robert DiCenso	Rhode Island	(401) 277-2566
Juan Lopez	George Warner	New York	(518) 474-8841
Dana Petrowsky	Juan Lopez	New Mexico	(505) 476-5636
Juanita Carrell	Dana Petrowsky	Iowa	(515) 281-3025
Fred Gladden			

Association of Health Facility Licensure and Certification Directors

Issues Committee
January 25, 1985

NURSING HOME AND HOSPITAL OWNERSHIP CHANGES

Report on Interstate Survey

INTRODUCTION

At its April 1984 executive board meeting the Association of State and Territorial Health Officials (ASTHO) asked the Association of Health Facilities Licensure and Certification Directors (AHFLCD) to explore the ability of the states to identify and sanction prospective health care providers who have a history of poor performance. As a result, the Issues Committee of the AHFLCD undertook a study to determine how states review health facility ownership changes, the sanction authority they possess and the feasibility of development and maintenance of a central registry of nursing home and hospital ownership which could be used by the states.

BACKGROUND

On July 25, 1984 the Issues Committee of AHFLCD discussed ownership entity change review processes of the states. The August board meeting in Seattle approved a questionnaire on this subject to be sent to all the states.

States with review authority may evaluate the potential owner's ability to provide quality care. In states with no authority for review, changes in ownership occur with no state control, which may significantly impact patient care and patient costs.

The type of ownership--proprietary vs. nonproprietary or chain vs. individual ownership--is not necessarily a good predictor of quality of care. However, particular owners or corporations may have established a history of poor patient care. Ideally, an application and review process should provide a thorough and careful analysis to identify purchasers with a history of poor care before an ownership change is approved.

Members of the Issues Committee and the board agreed that a nationwide survey of current state laws, procedures for reviewing ownership changes and suggestions for improving systems would be helpful to individual states. The results of this study could be used as a networking tool for those states establishing or modifying their review systems as well as to provide information regarding chain operations.

Two questionnaires were developed and sent to the Licensure and Certification Director in each state and the District of Columbia. The first questionnaire focused on ownership changes in a nursing home setting. The second concerned ownership changes in hospitals. This report presents the results from those questionnaires.

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Data has been received from thirty six states having some authority to review ownership changes in nursing homes through certificate of need or licensing authority. Six additional states indicated they do not have authority to review ownership changes. Twenty-seven states reported having authority to examine ownership changes in hospitals. Nine other states responded that they did not have that authority. The data was complied only for the states with authority to review ownership changes.

FINDINGS - NURSING HOME OWNERSHIP CHANGES

The attached table identifies each state with some review authority and the X's in the cells of the table represent affirmative answers to specific questions in the survey. A copy of the questionnaire, with the responses complied, is also included to show the frequency for each response category.

The results of two additional studies have been included in this analysis and are attached. The first is "Nursing Home Acquisitions: A Survey of State and Provincial Regulations." This study was conducted in June 1984 by the Washington State Senate Social and Health Services Committee. Senate staff members, Jane Habeggar and Marlen Blizinsky, conducted telephone interviews with nineteen states and two Canadian provinces to determine what, if any, regulations exist for controlling the acquisition of existing nursing home facilities. In addition, a nationwide study of certificate of need regulations was done by Rhode Island's Department of Health in March 1984.

There are several factors regarding review of ownership changes that are apparent when the three studies are analyzed. Those factors are:

- There is a wide variance in the level of awareness and interest in the issue of nursing home acquisition.
- For those states concerned with this issue, there are varied degrees of sophistication used in responding to it.
- Several states are introducing legislation to set a percentage limit on nursing home ownership by one individual or corporation. States are suggesting a cap on the percentage or absolute number of homes that can be owned by a single entity.
- The majority of states with review authority report having the authority to deny licensure.
- Of those reporting authority to deny licensure, approximately one half have actually done so.
- Generally, few states have conducted studies on this issue or have any ongoing compilation of data on the extent of nursing home ownership changes.

FINDINGS - HOSPITAL OWNERSHIP CHANGES

A table identifying each state with review authority for hospital ownership changes is included with this report. A copy of the hospital ownership change questionnaire is also attached showing the frequency for each response category.

Generally, the study suggest states tend to be less concerned about ownership changes in hospitals than in nursing homes. This might be attributed to the fact that a significant number of hospitals are publically owned. Additionally, the trend toward high industry concentration in nursing homes does not appear to be a major threat to local hospitals. It is unclear if this situation will change in the future.

CONCLUSIONS

There are indications that the Federal Government and individual states are becoming more concerned with the issue of nursing home ownership changes. This is especially true in light of growing facility acquisition by major corporations operating regionally and nationally.

National and multinational corporate structures have become extremely complex. It is often difficult to identify who has ultimate responsibility and legal accountability for actions of a health care facility. It is beyond the scope of this analysis to address this issue.

The importance of the issue, however, should not be dismissed. State governments need reliable means of knowing who is legally liable. A definitive, in-depth study, staffed with corporate legal experts is warranted.

It is anticipated the states will begin to pass more legislation regulating nursing home acquisitions. This, in turn, will necessitate the development and implementation of mechanisms to enforce new laws and regulations.

The studies presented here can be used as the beginning of a communication network for states currently faced with the problems of developing and implementing ownership, control and monitoring regulations for nursing homes and hospitals. Although there is less concern regarding ownership changes in hospitals, monitoring the situation is warranted. We have included rosters that identify individuals most knowledgeable about ownership changes in these states.

In addition, a central registry of health care facility owners as suggested by ASTHO in April 1984, could be developed to identify providers with poor performance records.

Currently, there are no formal means of determining prior sanctions imposed on operators in other states. Generally, sanctioned providers can move from state to state without threat of their prior performance becoming public or subject to state regulatory review. The main purpose of such a registry would be to assist states in screening potential new owners of facilities. Included in this registry would be information on owners doing business in more than one state, as well as information on Medicare/Medicaid certification, sanctions, terminations, and possibly other sanctions, including state licensure authority.

The Federal Government is ideally suited to serve as the focal point for establishing and maintaining a registry system. Owner information is available nationally from the Ownership and Control Interest Disclosure Statement (see attached). This form is filled out whenever ownership changes and is verified during each certification.

The most ideal situation would appear to be for the Federal Government to enter the owner disclosure information onto their MMACS system with a unique identifier per owner. The owner file would then be cross-referenced with the facility file currently available. This would allow the states immediate access to a listing of all facilities nationally owned or controlled by an individual. One state could contact the other states for detailed information on prior performance. There is also the possibility of linking to information on deficiencies available from the Federal MMACS system. In either case, a listing of past and current facilities owned by an applicant to purchase a facility would aid states to identify providers with a history of poor performance.

The rising trend in multiple home ownership and national nursing home chains raise concerns that can only be addressed by reviewing a prospective provider's past patient care record. Decisions then can be made to deny the sale of a home to a prospective provider with a history of poor patient care or to establish a more frequent monitoring program if ability to perform is questionable. This enhanced ability to predict provider performance appears to make investment in a central data system worthy of serious consideration.

It does appear developing a data system for ownership information and the coding of such information would be a major undertaking. The Federal Government is working on a project to redesign the disclosure form and to enter the information onto MMACS. Although the form is not ready for distribution or data entry at this time, the Federal Government has agreed to work with the states to use this form as the basis for the clearinghouse. Once the form is available, a meeting can be held with the Federal Government to develop a long-term written work plan for the development of a national clearinghouse.

It is possible that the GTE Telenet Medical Information Network (MINET) might be used as an interim step. MINET is an easily accessible medical information and communication network. Thirty two states are currently tied to it. The network enables any message, regardless of format, to be transmitted and distributed according to user specifications. For instance, a state could submit one inquiry regarding a prospective provider. This inquiry would be distributed simultaneously to all the states on the network. In turn, any response to the initial request is transmitted directly to the inquiring state bypassing all others. MINET could be used while the clearinghouse is being developed which would enable states to review prospective providers history immediately.

RECOMMENDATONS

- ASTHO pursue the possibility of funding a project to explore a means of identifying and tracking legally responsible owners of health care facilities involved in complex corporate organization structures.
- Individual states share information on their ability to review ownership change and to levy sanctions against prospective owners with a history of poor performance.
- AHFLCD direct the Issues Committee to continue work toward the development of a central national clearinghouse on performance of individuals involved in health care facility ownerships.
- The Association send this report to ASTHO in response to their original request that the Association review the ownership change matter.
- ASTHO and AHFCLD members explore the benefits of using Telenet on an interim basis for exchanging data on providers.
- That this report be shared with appropriate federal officials at HHS with an invitation for their review and comment.
- That the Association recommend to the Federal Government that they consider implementation of sanctions to prevent prospective owners with a record of poor patient care from being certified.

NURSING HOME
OWNERSHIP/ENTITY AND OPERATIONS CHANGES

State	CRITERIA FOR REVIEW OF OWNERSHIP CHANGES					SANCTIONS APPROVED BY SYSTEM		
	Financial Solvency	Transaction Prudent	Performance of New Owner	Ability to Correct Deficiencies	Criminal Convictions	Deny Licensing	Conditional License	Conditions of Operation
ALABAMA			X	X	X		X	X
ARKANSAS	X	X	X	X	X	X	X	X
ARIZONA			X	X	X	X	X	X
COLORADO	X		X	X	X	X	X	
CONNECTICUT			X				X	
D.C.	X	X	X	X	X			
DELAWARE	X	X	X		X	X	X	X
FLORIDA	X		X		X	X	X	
GEORGIA	X	X	X	X			X	
ILLINOIS	X					X		
KANSAS	X		X	X	X	X	X	X
KENTUCKY		X				X		
MARYLAND	X		X	X		X		
MICHIGAN				X	X	X	X	
MINNESOTA			X	X	X	X	X	X
MISSOURI	X		X		X	X	X	X
MONTANA	X	X	X	X				

States without Authority to Review Ownwership Changes in Nursing Homes: Alaska, Hawaii, Idaho, Iowa, North Dakota, Vermont.

State	CRITERIA FOR REVIEW OF OWNERSHIP CHANGES					SANCTIONS APPROVED BY SYSTEM		
	Financial Solvency	Transaction Prudent	Performance of New Owner	Ability to Correct Deficiencies	Criminal Convictions	Deny Licensing	Conditional License	Conditions of Operation
NEBRASKA	X	X	X	X		X		
NEVADA			X		X	X	X	
NEW JERSEY	X	X	X	X	X	X	X	X
NEW MEXICO	X	X			X	X	X	
NEW YORK	X	X	X	X	X	X	X	X
NORTH CAROLINA						X		X
OHIO	X		X	X	X	X	X	X
OREGON	X			X		X	X	X
PENNSYLVANIA			X	X	X	X	X	X
RHODE ISLAND	X	X	X	X	X	X	X	X
SOUTH CAROLINA	X	X	X	X	X	X		
SOUTH DAKOTA						X	X	X
TENNESSEE							X	X
TEXAS						X	X	X
UTAH	X					X		
VIRGINIA						X	X	X
WASHINGTON	X		X	X	X	X		

State	CRITERIA FOR REVIEW OF OWNERSHIP CHANGES					SANCTIONS APPROVED BY SYSTEM		
	Financial Solvency	Transaction Prudent	Performance of New Owner	Ability to Correct Deficiencies	Criminal Convictions	Deny Licensing	Conditional License	Conditions of Operation
WEST VIRGINIA	X					X		
WISCONSIN	X		X	X	X	X	X	X
WYOMING						X		

State	License Denied	Appeal Possible	Informal Appeal Process	System Ever Challenged	Central Registry of Owners	Reviews Management/ Administration Changes	Conducting Studies on Ownership Changes	Compiles Statistics on Ownerships
ALABAMA					X	X		
ARIZONA		X	X			X		
COLORADO	X	X	X			X		X
CONNECTICUT						X		
D.C.		X	X		X			
DELAWARE	X	X	X		X			
FLORIDA		X	X					
GEORGIA								
ILLINOIS		X			X	X		X
KANSAS	X	X		X		X		
KENTUCKY		X						
MARYLAND		X	X		X	X		
MICHIGAN	X	X	X	X		X		
MINNESOTA	X	X				X	X	
MISSOURI	X	X			X			
MONTANA								X

Nursing Home Ownership/Entity and Operation Changes
Page Five

State	License Denied	Appeal Possible	Informal Appeal Process	System Ever Challenged	Central Registry of Owners	Reviews Management/ Administration Changes	Conducting Studies on Ownership Changes	Compiles Statistics on Ownerships
NEBRASKA	X	X				X		
NEVADA		X	X			X		
NEW JERSEY	X	X	X					
NEW MEXICO		X	X		X	X		
NEW YORK	X	X	X	X		X	X	X
NORTH CAROLINA	X	X	X	X	X	X		
OHIO	X	X		X	X	X		
OREGON	X	X			X	X		
PENNSYLVANIA	X				X	X		X
RHODE ISLAND		X	X			X		
SOUTH CAROLINA		X						
SOUTH DAKOTA	X	X	X		X		X	
TENNESSEE								
TEXAS	X	X		X	X	X		
UTAH						X		
VIRGINIA		X	X		X	X		
WASHINGTON		X				X	X	

State	License Denied	Appeal Possible	Informal Appeal Process	System Ever Challenged	Central Registry of Owners	Reviews Management/ Administration Changes	Conducting Studies on Ownership Changes	Compiles Statistics on Ownerships
WEST VIRGINIA		X	X			X		
WISCONSIN	X	X	X		X	X		X
WYOMING		X	X		X			

CON PROVISIONS CONCERNING CHANGES IN EFFECTIVE CONTROL OF HEALTH CARE FACILITIES
RHODE ISLAND DEPARTMENT OF HEALTH

State	CON Review of Changes in Effective Control	No CON Review unless change in service, capacity, etc.	No Review Authority	Medicaid Denial Authority	Licensure* Denial Authority
Alabama		See "Alabama" below			
Alaska		No statutory basis for any type of review			
Arizona		X			
Arkansas		X		No	No
California		X		No	No
Colorado	CON Review only for L.T.C. homes, if poor quality found			No No	No No
Connecticut		X		No	Yes, if not good moral character
Delaware		X			
D.C.	X			No	No
Florida		X (See "Florida" below)		No	
Georgia	Reviews transfers of ownership through 1122			No	No
Hawaii				No	No
Idaho			X		
Illinois			(X) CON Expired 6-83	No	No
Indiana		X	X	No	No
Iowa				No	No
Kansas			X X	No No	No Limits no. of Adult Care Homes owned by 1 owner
Kentucky			X		
Louisiana	Only mergers of sales (100%) of stock reviewed			No	No
Maine		X		No	No
Maryland		X		No No	No No (Attempts Administrative denials
Massachusetts	CON reviews changes of ownership only				
Michigan		X		No	No
Minnesota				No	No
Mississippi	X		X CON Sunset 6-84	No	No
Missouri			X	No	No

State	CON Review of Changes in Effective Control	No CON Review unless change in service, capacity, etc.	No Review Authority	Medicaid Denial Authority	Licensure* Denial Authority
Montana		X		No	No
Nebraska			X	No	No
Nevada		X		No	No
New Hampshire	CON must review transfers of ownership only			No	No
New Jersey	X			No	No
New Mexico			X	Yes	No
New York	X				
No. Carolina			X	No	No
No. Dakota		X		No	No
Ohio			X	No	No
Oklahoma			X	No	No
Oregon			X	No	No
Pennsylvania		X		No	No
Rhode Island	X				
So. Carolina	(under Medicaid authority)		X	Yes	No
So. Dakota			X	No	No
Tennessee			X		
Texas		X		No	No
Utah			X		
Vermont			X	No	No
Virginia		X		No	No
Washington	See "Washington" below				
W. Virginia	X			No	No
Wisconsin	CON required for hospitals only			No	Yes (financial viability criteria
Wyoming		X		No	No

* A "No" in this column means that the licensing agency generally will collect prescribed data on a new owner, then issue a new license similar to R.I.'s present procedure.

NURSING HOME ACQUISITIONS: A SURVEY OF STATE AND PROVINCIAL REGULATIONS

STATE OR PROVINCE	REGULATE NURSING HOME ACQUISITIONS?	STATE STUDIES CURRENTLY BEING CONDUCTED?	COMPILE STATISTICS ON NURSING HOME OWNERSHIP BY NUMBER AND SIZE OF FACILITIES OWNED?	DOES STATE REGULATE PRIVATE PATIENT RATES?
Alabama	No	No	No	No
Arkansas	No	No	No	No
British Columbia	No	No	No	No
California	Yes. Administrative code permits denial of operator's license based on outstanding citations within state. Operator and members and shareholders, if any, must show that it (they) is (are) "of reputable and responsible character" Bill placing 20% ownership cap in geographic area introduced last session.	Yes; Commission on California State Government Organization and Economy is examining the effects of corporate acquisitions of nursing homes.	Yes	No
Colorado	Yes; through licensing agency. Do not allow acquisition if financially unstable or have history of not meeting standards.	Yes; Department of Social Service, Long-Term Care Section is examining effects of corporate acquisitions of nursing homes.	No	If private rates are lower than public rates, the public rate will be lowered so public won't subsidize private patients.

STATE OR PROVINCE	REGULATE NURSING HOME ACQUISITIONS?	STATE STUDIES CURRENTLY BEING CONDUCTED?	COMPILE STATISTICS ON NURSING HOME OWNERSHIP BY NUMBER AND SIZE OF FACILITIES OWNED?	DOES STATE REGULATE PRIVATE PATIENT RATES?
Florida	Yes; through C of N. Currently working on rule which provides for a review of the quality of care historically provided by the buyer.	No	No	No
Georgia	No. Do require certain information be filed under §1122 of Social Security Act.	No	No	Yes; private rates cannot exceed public rates. backward
Illinois	Yes. Statute permits Dept. of Public Health to grant license only if individual or firm is "responsible and suitable ... by virtue of financial capacity, appropriate business or professional experience, [has] a record of compliance with lawful orders of the Department" and has not had a license revoked within the previous 5 years.	No	No	No
Indiana	No	No	Yes	No
Iowa	No	No	No	No
Kentucky	No. Bill limiting individual and corporate ownership to no more than 5 homes in state introduced last session.	No	No	No
Maryland	Yes; through licensing. Denial permitted based on applicant's "financial or administrative ability" as evidenced by "past or current performance" both within state and outside.	No	No	No

STATE OR PROVINCE	REGULATE NURSING HOME ACQUISITIONS?	STATE STUDIES CURRENTLY BEING CONDUCTED?	COMPILE STATISTICS ON NURSING HOME OWNERSHIP BY NUMBER AND SIZE OF FACILITIES OWNED?	DOES STATE - - REGULATE PRIVATE PATIENT RATES?
Michigan	Yes; under §1122 of the Social Security Act if the buyer is seeking an increase in Medicaid reimbursement based upon a new basis of the property value.	No	Yes	No
Minnesota	No; but legislature considered a bill creating a 10% lid on ownership of nursing homes by one individual or corporation. Also no increase in reimbursement due to the sale will be acknowledged. Moratorium on new construction.	Yes; legislation passed requiring the Department of Human Services to study the issue cooperatively with the Department of Health and report back to legislature.	Yes	Yes; private rates cannot exceed publ rates (Medicaid)
Mississippi	Yes; 20% cap on ownership by one individual or corporation in statute. Prior to that had rule which allowed maximum of 25% ownership by individual or corporation.	No	No	No
Missouri	No; but moratorium on new construction.	No	No; no computer so would have to be done manually.	No
Nebraska	Yes; under certificate of need. Examine 17 criteria including effect on Medicaid rates. Recent change in statute to review stock acquisitions also. Bill introduced with 25% cap on ownership in last session of legislature.	No	No; not familiar enough with names of corporations and subsidiaries to identify them.	

STATE OR PROVINCE	REGULATE NURSING HOME ACQUISITIONS?	STATE STUDIES CURRENTLY BEING CONDUCTED?	COMPILE STATISTICS ON NURSING HOME OWNERSHIP BY NUMBER AND SIZE OF FACILITIES OWNED?	DOES STATE REGULATE PRIVATE PATIENT RATES?
New York	Yes; statute enforced by Public Health Council prohibits acquisition "by a limited partnership ... by a partnership any of the members of which are not natural persons" or "which would be operated by a corporation any of the stock of which is owned by another corporation." Public Health Council must also find that incorporators, directors, sponsors or operator if previously associated with a facility, offers or offered "a substantially consistent high level of care."	No	No	No
North Dakota	No	No	Yes	No
Ontario	Yes; through licensing agency. Purchasers must obtain new license for purchased home. Agency can deny license based on financial insolvency or record of past violations.	Yes. Special Corporate Projects Office studying differences in quality of care given by for-profit and nonprofit homes.	No	N/A
Oregon	No	No	Near completion	No
South Dakota	No, but new owner must meet licensing standards.	Yes; by legislative committee and executive branch.	No	No
Texas	No	No	No	No

NURSING HOME OWNERSHIP/ENTITY AND OPERATOR CHANGES

SUMMARY OF RESPONSES

(Total of Responses = 42)

Respondent ____________________

Title ____________________

State ____________________

Telephone Number ____________________

PART I - OWNERSHIP CHANGES

1. The following situations may constitute an ownership change in the nursing home industry. Please circle those below and specify others that your state recognizes as an ownership change.

   a. Sole proprietorship incorporates...owners remain the same.
   b Partnership incorporates...owners remain the same.
   c Change in partnership...minimum of one owner remaining the same.
   d. Facility sold...all owners change.
   e. Corporate merger...some owners change
   f. Other (Please Specify) ____________________

2. Does your state have the authority to review these ownership changes through Certificate of Need or Licensing authority?

   36 YES 6 NO

   If yes: Please send copies of the law, regulation, or policy that documents your authority to review ownership changes. Provided is a self-addressed envelope for your convenience.

IF YOU DO NOT HAVE A SYSTEM TO REVIEW OWNERSHIP CHANGES, PLEASE SKIP TO PART II

3. Briefly describe your primary objectives for reviewing ownership changes.

N = 36

N %

4. Which of the following criteria does your state use for review? (Circle each applicable criteria and provide a brief description of the process used):

22 61 a. Financial solvency of buyer

11 31 b. Demonstration that the business transaction is prudent and reasonable

23 64 c. Past and/or current performance of new owner with respect to health care related entities

N %

20 56 d. Demonstrated ability to correct any deficiencies cited.

~~e. Local or community needs which may alter statewide criteria~~

20 56 f. Any known civil or criminal convictions of new owner.
-Felony Convictions
-Medicaid fraud was often cited.

g. Other (Please Specify)

5. What sources of information do you access for your review?

16 44 6. Do you maintain a central registry of such information?

[✓ YES] NO

~~7. Is the information subject to public disclosure~~?

YES NO

8. Which of the following have been authorized by your system in the review process? (circle all applicable responses):

30 83 a. Deny licensing
24 67 b. Require specific improvements/provisional or conditional license
18 50 c. Require specific conditions of operation
~~d. Mandate Medicaid participation.~~
e. Other (Please Specify)

N = 30

N % 9. If you have authority to deny licensing, have you ever done so?

16 53 [✓ YES] NO

If yes: Answer questions 10 and 11.

10. How many have been denied?

2 - 5 most common response

Missouri reported 83 denials since May 1982

11. On what basis was the license denied?

History of Medicaid fraud
Financial considerations
Non compliance with licensure requirements
Duplication of service in community

29 97 12. If you have authority to deny licensing, does your denial process provide for appeal?

[✓ YES] NO

If yes: Answer questions 13 to 16.

13. Briefly describe the appeal process. (Please send a copy of the appeal procedures)

18 60 14. Does the appeal system include an informal process?

N = 36 [✓ YES] NO

N % 15. Has the review system been challenged?

6 17 [✓ YES] NO

If yes: Answer questions 16 and 17.

16. Was the review system upheld or modified?

17. If modified, how?

N = 36

N %

PART II - MANAGEMENT CHANGES

25 69 ____ 1. Does your state have a system to review management/administrator changes?

/ YES /   NO

If yes: Please answer question 2 and 3.

2. List each criteria used in your review and provide a brief description of the process used.

3. Please list actions you are able to take in the event the new management does not meet criteria outlined in question 2.

4 11 ____ 4. Is your state conducting studies regarding ownership/management changes?

/ YES /   NO

If yes: Please describe -

6 17 ____ 5. Do you compile statistics on nursing home ownership/management. (Please attach samples of your reports)

/ YES /   NO

HOSPITAL
OWNERSHIP/ENTITY AND OPERATIONS CHANGES

State	CRITERIA FOR REVIEW OF OWNERSHIP CHANGES					SANCTIONS APPROVED BY SYSTEM		
	Financial Solvency	Transaction Prudent	Performance of New Owner	Ability to Correct Deficiencies	Criminal Convictions	Deny Licensing	Conditional License	Conditions of Operation
ALABAMA			X	X	X		X	X
ARKANSAS	X	X	X	X	X	X	X	X
ARIZONA			X	X	X	X	X	X
COLORADO	X		X	X	X	X	X	
DELAWARE	X	X	X		X	X	X	X
FLORIDA						X	X	
ILLINOIS	X	X	X	X	X	X	X	
INDIANA	X	X	X	X	X	X		X
KENTUCKY		X				X		
MICHIGAN				X	X	X	X	X
MINNESOTA			X	X	X	X		
MONTANA								X
NEVADA			X		X	X	X	
NEW MEXICO	X	X			X	X		

States without Authority to Review Ownership Changes in Hospitals: Alaska, Hawaii, Idaho, Iowa, Kansas, Maryland, North Dakota, Ohio, Vermont.

Hospital Ownership/Entity and Operation Changes
Page Two

State	CRITERIA FOR REVIEW OF OWNERSHIP CHANGES					SANCTIONS APPROVED BY SYSTEM		
	Financial Solvency	Transaction Prudent	Performance of New Owner	Ability to Correct Deficiencies	Criminal Convictions	Deny Licensing	Conditional License	Conditions of Operation
NEW YORK	X	X	X	X	X	X	X	X
NORTH CAROLINA								X
PENNSYLVANIA			X	X	X	X	X	X
RHODE ISLAND	X	X	X	X	X	X	X	X
SOUTH CAROLINA	X	X	X	X	X	X		
SOUTH DAKOTA				X	X	X	X	X
TENNESSEE						X	X	
UTAH	X				X	X		
VIRGINIA						X		
WASHINGTON	X	X	X		X			
WEST VIRGINIA	X							
WISCONSIN	X	X				X		X
WYOMING						X		

Hospital Ownership/Entity and Operation Changes
Page Three

State	License Denied	Appeal Possible	Informal Appeal Process	System Ever Challenged	Central Registry of Owners	Reviews Management/ Administration Changes	Conducting Studies on Ownership Changes	Compiles Statistics on Ownerships
ALABAMA					X	X		
ARKANSAS		X	X		X			X
ARIZONA	X	X	X			X		
COLORADO		X	X			X		X
DELAWARE	X	X	X		X			
FLORIDA		X	X					
ILLINOIS		X	X					
INDIANA	X	X	X	X	X	X		
KENTUCKY		X						
MICHIGAN	X	X	X		X			
MINNESOTA	X	X				X		
MONTANA								X
NEVADA		X	X			X		
NEW MEXICO		X	X		X	X		

State	License Denied	Appeal Possible	Informal Appeal Process	System Ever Challenged	Central Registry of Owners	Reviews Management/ Administration Changes	Conducting Studies on Ownership Changes	Compiles Statistics on Ownerships
NEW YORK	X	X	X	X		X	X	X
NORTH CAROLINA	X	X	X	X	X			
PENNSYLVANIA								
RHODE ISLAND		X	X			X		
SOUTH CAROLINA		X				X		
SOUTH DAKOTA	X	X	X		X		X	
TENNESSEE								
UTAH						X		
VIRGINIA		X	X		X	X		
WASHINGTON		X						
WEST VIRGINIA								
WISCONSIN	X	X	X		X			
WYOMING		X	X		X			

HOSPITAL OWNERSHIP/ENTITY AND OPERATOR CHANGES

SUMMARY OF RESPONSES

(Total Of Responses = 36)

Respondent ______________________

Title ______________________

State ______________________

Telephone Number ______________________

PART I - OWNERSHIP CHANGES

1. The following situations may constitute an ownership change in the hospital industry. Please circle those below and specify others that your state recognizes as an ownership change.

   a. Sole proprietorship incorporates...owners remain the same.
   b Partnership incorporates...owners remain the same.
   c Change in partnership...minimum of one owner remaining the same.
   d. Facility sold...all owners change.
   e. Corporate merger...some owners change
   f. Other (Please Specify) ______________________

2. Does your state have the authority to review these ownership changes through Certificate of Need or Licensing authority?

   __27__ YES __9__ NO

   If yes: Please send copies of the law, regulation, or policy that documents your authority to review ownership changes. Provided is a self-addressed envelope for your convenience.

IF YOU DO NOT HAVE A SYSTEM TO REVIEW OWNERSHIP CHANGES, PLEASE SKIP TO PART II

3. Briefly describe your primary objectives for reviewing ownership changes.

N = 27 4. Which of the following criteria does your state use for review? (Circle each applicable criteria and provide a brief description of the process used):

N %

13 48 a. Financial solvency of buyer

11 41 b. Demonstration that the business transaction is prudent and reasonable

14 52 c. Past and/or current performance of new owner with respect to health care related entities

N %

13 48 d. Demonstrated ability to correct any deficiencies cited.

e. ~~Local or community needs which may alter statewide criteria~~

18 67 f. Any known civil or criminal convictions of new owner.

g. Other (Please Specify)

5. What sources of information do you access for your review?

11 41 6. Do you maintain a central registry of such information?

[✓ YES] NO

7. ~~Is the information subject to public disclosure~~?

YES NO

8. Which of the following have been authorized by your system in the review process? (circle all applicable responses):

22 81 a. Deny licensing
14 52 b. Require specific improvements/provisional or conditional license
13 48 c. Require specific conditions of operation
d. Mandate Medicaid participation
e. Other (Please Specify)

N = 22

N % 9. If you have authority to deny licensing, have you ever done so?

9 41 [✓ YES] NO

If yes: Answer questions 10 and 11.

10. How many have been denied?

11. On what basis was the license denied?

21 95 12. If you have authority to deny licensing, does your denial process provide for appeal?

[✓ YES] NO

If yes: Answer questions 13 to 16.

13. Briefly describe the appeal process. (Please send a copy of the appeal procedures)

17 80 14. Does the appeal system include an informal process?

N = 27 [✓ YES] NO

3 11 15. Has the review system been challenged?

[✓ YES] NO

If yes: Answer questions 16 and 17.

16. Was the review system upheld or modified?

17. If modified, how?

PART II - MANAGEMENT CHANGES

N = 27 1. Does your state have a system to review management/administrator changes?

N %

12 44 [✓ YES] NO

If yes: Please answer question 2 and 3.

2. List each criteria used in your review and provide a brief description of the process used.

3. Please list actions you are able to take in the event the new management does not meet criteria outlined in question 2.

2 7 4. Is your state conducting studies regarding ownership/management changes?

[✓ YES] NO

If yes: Please describe -

4 15 5. Do you compile statistics on hospital ownership/management. (Please attach samples of your reports)

[✓ YES] NO

Department of Health and Human Services
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No 68-R-0131

OWNERSHIP AND CONTROL INTEREST DISCLOSURE STATEMENT

AS A CONDITION OF PARTICIPATION, CERTIFICATION, OR RECERTIFICATION UNDER ANY OF THE PROGRAMS ESTABLISHED BY TITLES V, XVIII, XIX, AND XX, OR AS A CONDITION FOR APPROVAL OR RENEWAL OF A CONTRACT OR AGREEMENT BETWEEN THE DISCLOSING ENTITY AND THE SECRETARY OR APPROPRIATE STATE AGENCY UNDER ANY OF THE ABOVE-TITLED PROGRAMS, A FULL AND ACCURATE DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST IS REQUIRED (42 U.S.C. 1320a-3) FAILURE TO SUBMIT REQUESTED INFORMATION MAY RESULT IN A REFUSAL BY THE SECRETARY OR APPROPRIATE STATE AGENCY TO ENTER INTO AN AGREEMENT OR CONTRACT WITH ANY SUCH INSTITUTION OR IN TERMINATION OF EXISTING AGREEMENTS

I IDENTIFYING INFORMATION

NAME OF ENTITY	D/B/A	PROVIDER #	VENDOR #	CONTRACT NO TITLE V	 TITLE XX
STREET ADDRESS	CITY COUNTY STATE		ZIP CODE	TELEPHONE NO	
GOVERNMENT OWNERSHIP ☐ Yes ☐ No	CHAIN AFFILIATE ☐ Yes ☐ No				

II ANSWER THE FOLLOWING QUESTIONS BY CHECKING "YES" OR "NO" IF ANY OF THE QUESTIONS ARE ANSWERED "YES", LIST NAMES AND ADDRESSES OF INDIVIDUALS OR CORPORATIONS ON AN ATTACHED SHEET

	YES	NO
A ARE THERE ANY INDIVIDUALS OR ORGANIZATIONS HAVING A DIRECT OR INDIRECT OWNERSHIP OR CONTROL INTEREST OF 5 PERCENT OR MORE IN THE INSTITUTION, ORGANIZATION, OR AGENCY THAT HAVE BEEN CONVICTED OF A CRIMINAL OFFENSE RELATED TO THE INVOLVEMENT OF SUCH PERSONS, OR ORGANIZATIONS IN ANY OF THE PROGRAMS ESTABLISHED BY TITLES XVIII, XIX, OR XX		
B ARE THERE ANY DIRECTORS, OFFICERS, AGENTS OR MANAGING EMPLOYEES OF THE INSTITUTION, AGENCY, OR ORGANIZATION WHO HAVE EVER BEEN CONVICTED OF A CRIMINAL OFFENSE RELATED TO THEIR INVOLVEMENT IN SUCH PROGRAMS ESTABLISHED BY TITLES XVIII, XIX, OR XX		
C ARE THERE ANY INDIVIDUALS CURRENTLY EMPLOYED BY THE INSTITUTION, AGENCY, OR ORGANIZATION IN A MANAGERIAL, ACCOUNTING, AUDITING OR SIMILAR CAPACITY WHO WERE EMPLOYED BY THE INSTITUTION'S, ORGANIZATION'S, OR AGENCY'S FISCAL INTERMEDIARY OR CARRIER WITHIN THE PREVIOUS 12 MONTHS (TITLE XVIII PROVIDERS ONLY)		

IF YOU NEED ADDITIONAL SPACE FOR ANY OF THE FOLLOWING ITEMS, ATTACH A SEPARATE SHEET AND CLEARLY INDICATE WHICH ITEM IS BEING CONTINUED IF MORE THAN ONE INDIVIDUAL IS REPORTED AND ANY OF THE PERSONS NAMED ARE RELATED TO EACH OTHER (E.G. SPOUSE, CHILD, PARENT, SIBLING), THIS MUST BE REPORTED AND SHOULD BE INDICATED ON THE FORM

III TYPE OF ENTITY

☐ SOLE PROPRIETORSHIP — A IF SOLE PROPRIETORSHIP, LIST NAME OF OWNER ______
☐ PARTNERSHIP — B IF PARTNERSHIP LIST NAMES OF PARTNERS ______
☐ CORPORATION — C IF CORPORATION GIVE NAME OF CORPORATION ______
☐ OTHER (SPECIFY) ______

IV LIST NAMES AND ADDRESSES OF INDIVIDUALS OR ORGANIZATIONS HAVING DIRECT OR INDIRECT OWNERSHIP INTERESTS SEPARATELY OR IN COMBINATION, AMOUNTING TO AN OWNERSHIP INTEREST OF 5 PERCENT OR MORE IN THE DISCLOSING ENTITY INDIRECT OWNERSHIP INTEREST IS OWNERSHIP INTEREST IN AN ENTITY THAT HAS AN OWNERSHIP INTEREST IN THE DISCLOSING ENTITY OWNERSHIP IN ANY ENTITY HIGHER IN A PYRAMID THAN THE DISCLOSING ENTITY CONSTITUTES INDIRECT OWNERSHIP

NAME	ADDRESS

V LIST NAMES AND ADDRESSES OF INDIVIDUALS OR ORGANIZATIONS HAVING OWNERSHIP INTEREST (EQUAL TO AT LEAST 5 PERCENT OF THE ENTITY'S ASSESTS) IN A MORTGAGE OR OTHER OBLIGATION SECURED BY THE DISCLOSING ENTITY

NAME	ADDRESS

VI IF THE DISCLOSING ENTITY IS A CORPORATION, LIST NAMES, ADDRESSES, AND TITLES OF THE OFFICERS AND DIRECTORS

	NAME	TITLE	ADDRESS
A OFFICERS			
B DIRECTORS			

VII LIST NAMES AND ADDRESSES OF ANY INDIVIDUALS OR ORGANIZATIONS THAT HAVE AN OWNERSHIP OR CONTROL INTEREST OF 5 PERCENT OR MORE IN A SUBCONTRACTOR IN WHICH THE DISCLOSING ENTITY HAS A DIRECT OR INDIRECT OWNERSHIP INTEREST OF 5 PERCENT OR MORE (ALSO, LIST NAMES AND ADDRESSES OF THOSE SUBCONTRACTORS.)

NAME	ADDRESS

VIII LIST NAMES OF OTHER DISCLOSING ENTITIES IN WHICH ANY OF THE PERSONS IDENTIFIED IN SECTIONS III THROUGH VII ALSO HAVE AN OWNERSHIP OR CONTROL INTEREST. (THIS INFORMATION IS REQUIRED TO THE EXTENT THAT THE REPORTING ENTITY CAN OBTAIN IT BY REQUESTING IT IN WRITING FROM THE PERSON.)

NAMES	OTHER DISCLOSING ENTITIES

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE

NAME OF AUTHORIZED REPRESENTATIVE (TYPED)	TITLE
SIGNATURE	DATE

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

April 14, 1986

Mr. James Michie
Chief Investigator
Senate Special Committee on Aging
Dirksen Building, Room G-33
Washington, D. C. 20510

Dear Jim:

This is to confirm agreements that we reached with you on April 8 concerning the disclosure of certain information extracted from the Health Care Financing Administration's Medicare/Medicaid Automated Certification System (MMACS).

During our meeting that day to discuss preparing for an April 30 hearing on the enforcement of nursing home standards, you requested we provide you information that would help you identify cases of facilities' chronic noncompliance with federal nursing home standards. We agreed to provide you, from HCFA's MMACS data base, a list of nursing home names and addresses, by state, that specifies facilities that failed to comply with certain nursing home requirements for the last three surveys, as reported in the MMACS file as of November 30, 1985. After discussing the limitations of using MMACS data on a superficial level without analyzing the details of individual cases, you stated you did not intend to disclose the names of those nursing homes--and possibly would not even disclose which states would be represented in discussing those individual cases--during the hearing. It was also agreed that the names of the 10 nursing homes for which we have developed case studies would not be disclosed.

I understand you received the names and addresses of these nursing homes on April 11, and this satisfied your request. Please call me if you have any questions regarding the agreements reached.

Sincerely,

James R. Linz
Group Director

KENNETH OLSHANSKY, M. D., LTD.

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SUITE 203, 7660 PARHAM ROAD
TELEPHONE (804) 346-2897

April 21, 1986

Senator H. John Heinz
Chairman of the Special Committee
on Aging
United States Senate
Room G-33 Dirkson Building
Washington, D.C. 10510

Dear Senator Heinz:

I am writing this letter to discuss some of my thoughts regarding Nursing Home care to the elderly. I am a plastic surgeon who consults frequently in Nursing Homes on a regular basis and have first hand exposure to care of the elderly. Before writing this letter I want to apologize if it seems somewhat disorganized however I will try to get my thoughts down to the best of my ability.

I would like to first discuss some of my concerns regarding the process by which Nursing Homes are licensed and the availability of Nursing Home beds. Here in Virginia, a Nursing Home must receive a Certificate of Need before building a Nursing Home. At the present time patients are spending weeks to months in hospitals waiting for Nursing Home beds to become available. The problem is that there are not enough beds both skilled and intermediate care to satisfy the needs of the elderly. Because patients are taking up acute care beds the expenses obviously are much greater. One has to ask why is there such a lack of Nursing Home beds. I feel that the answer rests with several factors including the Certificate of Need and the lack of competition and incentive in the market place. At the present time there is absolutely no competition for Nursing Home beds and families will take the first bed available even though the Nursing Home may not have the best quality of care. With DRG requirements, patients are being pressured to leave the hospital as soon as possible and as a result the families are under pressure to take the first Nursing Home bed available. At the present time because it is a "seller's market", the Nursing Homes can keep their beds filled without having to compete on a quality basis. As long as they meet minimum standards, they can not only remain full, but often have waiting lists. I question why doesn't the government allow free competition in the market place for Nursing Homes but of course at the same time maintaining strict regulations. I feel that this would allow Nursing Homes to have to be more competitive and hopefully the ones with the better reputations giving the best care, will survive and be more successful than those who do not give quality care. To keep down the number of available beds in Nursing Homes I feel is counter productive to not only cutting costs but cutting quality.

One of the interim solutions which I feel would be of benefit since most hospitals across the country are not at full occupancy, would be to allow empty beds to be converted into so called "swing beds". These beds would become essentially Nursing Home beds at the time that patients are able to leave an acute care facility and the hospital will obviously receive a reduced rate for these beds. In fact the rates may even be lower than the Nursing Home rate. Many times patients may be able to complete less intensive treatments such as physical therapy in the hospital and bypass the need to go to a Nursing Home. With all of the patients who are waiting around for so many days to get into Nursing Homes, there must be a way to decrease the cost to both the hospitals as well as to Medicare and Medicaid.

My other concern regarding Nursing Homes is the discrepancy in the levels of care from one Nursing Home to another. Let me preface my remarks with saying that I feel strongly that most Nursing Homes in this country do an excellent job and the people taking care of our elderly should be commended for performing this difficult task. However I would like to address some thoughts regarding some of those Nursing Homes who are only giving minimal care as well as substandard care. Again I think these are in the minority but need to be addressed.

In Richmond, Virginia two examples come to mind regarding Nursing Homes who are giving excellent care. One is a non profit Home which is run by one of the religious denominations. From the Administrator, the Lay Board, the nursing supervisors, to the community and families, quality care is expected and demanded. There are multiple patient conferences discussing individual patient needs, there are a large amount of volunteer programs, as well as community involvement. As a result not only are the medical needs met for the patients, but their psychological and social needs are also addressed. In addition there is a Nursing Home which is owned by a private individual who takes a great deal of pride in the type of care that is given and his entire staff is very much attuned to quality care and as a result the patients in his Nursing Home are given excellent treatment. On the other hand I go to many other Nursing Homes where the staff appears to be poorly trained, understaffed and there does not appear to be strict supervision at all levels. As a result a person going into one of these types of Nursing Homes may in fact get much less quality care both from a medical and psychological aspect than in some of the other and better run Nursing Homes. One has to ask why is there such a discrepancy and if there was more competition would these Nursing Homes have to provide a better atmosphere in order to stay in business.

In addressing the differences in quality care in Nursing Homes, obviously the most important aspects are the philosophy of the Directors of the Nursing Homes as well as the training of the staff. I go into many Nursing Homes where patients have broken down with large bed sores simply because they were not turned or gotten out of bed on a routine basis. The cost of staffing to get patients out of bed into a chair or turn them is quite minimal compared to the cost of treating patients with large bed sores. Once a patient has skin breakdown and develops large pressure ulcers, patients often require intensive local wound care which requires one or two nurses or aids, they require dressings and antibiotics, whirlpool treatments, and often many hospitalizations for infection and complications as well as operative procedures. This all adds up with not only costs but severe pain and emotional strain on the patient as well as their families and all of the staff. This is just one example of an aspect of care which often is not given in a Nursing Home.

In summarizing I would like to make several points. I feel very strongly that if we are to upgrade the quality of care to our elderly, the families, communities and government have to work together with the business community to see that quality care and availability of Nursing Home beds are achieved. I feel that the government still has to be the "watchdog" to maintain the minimal requirements but on the other hand I feel that the free market place will force a more competitive atmosphere where the so called "patient consumer" can demand more for their dollar. If patients do not get the care they expect, they can pick up and leave and go to another Nursing Home down the street. I would also like to again reiterate that working in a Nursing Home is an extremely demanding and frustrating job at times but of course can be very rewarding as well. I feel it is very important to establish in the system, an incentive for delivering quality care. I feel that all of those Nursing Homes who are doing a good job, should somehow be rewarded whether it is financially or some other form of recognition. On the other hand, those Nursing Homes who are not giving quality care, should somehow be put on notice that unless conditions improve, that they will no longer be able to function.

I certainly understand that this is an extremely complex problem in terms of finding a balance between government reimbursement, and cost containment as well as delivering quality care. I feel confident that there is a system that can work and if I can be of any help in further addressing my views, please do not hesitate to contact me.

I appreciate your giving me the opportunity to express myself.

Sincerely,

Kenneth Olshansky, M.D.

kb/

P.O. Box 176
Bodega Bay, CA 94923

May 12, 1986

Senator John Heinz
Chairman, Senate Special Committee on Aging
Dirksen Building, Room G-33
Washington, DC 20510

Attn: David Schulke

Dear Senator Heinz:

Enclosed please find my testimony regarding "nursing homes." I am sending this by overnight express mail and apologize for the lateness. I wasn't able to put the words down until now and have not done a decent editing of the material. Please edit at your discretion. You have my permission to use any part of the enclosed or to omit excess verbage. I am too close to it presently and cannot do a credible exorcism.

I remain eager and willing to do anything within my power to help you ease the pain and suffering of our elderly, both physically and emotionally. I can be reached at most easily early morning and evening. If all else fails, call evenings. My address is above.

Sincerely,

Donna R. Freeman

Donna R. Freeman

I am the daughter of an 87 year old female caucasion who was a public school teacher for over 45 years. Five years ago she was diagnosed as having Alzheimer's disease. This is devastating to any family, and when you are least able to deal with the emotional trauma is when you have to deal with what we mistakingly call nursing homes.

In April of 1985 I filed a lawsuit on behalf of my mother, who was a resident of a Sonoma County nursing home owned by one of the largest nursing home corporations in the United States. I chose to place my mother in this facility because it was clean, had very little urine odor and seemed much more pleasant than most, even though it meant a three-hour round trip for me. My grounds for the suit were that my mother was not restrained when put to bed on a particular night and at 11:00 PM climbed over her bed rails, fell to the floor, and broke her hip. A faulty assessment of her injuries resulted in her being returned to bed, family not notified, physician not called until late next morning, and patient fed lunch and breakfast before being taken (screaming in pain) by ambulance to hospital for hip replacement surgery. Examination showed hip rotated in socket. She was in great pain and surgery had to be delayed because she had been fed. The emotional trauma was horrible, as she could not remember why she had pain nor understood what was happening to her. This facility was cited by the State for failure to notify physician, lack of charting, etc., etc. My mother's injuries are permanent. She no longer can walk unaided and is confined to a wheelchair most of the time. In April of this year I settled my mother's case out of court.

After her surgery my mother was transferred to a nursing facility in Santa Rosa, CA where she remaind for three days until we could find another place. During this long three days, I witnessed the following: Some patient's medications were left on the windowsill, curtains and walls filthy, attendants not to be found for a half-hour time period. Mother was diapered upon entry, even though she was not incontient. Aides were given no instructions nor had any knowledge of her injury or how to care for her. Bed linens were threadbare and badly stained. Facility as a whole was filthy with terrible odor. As soon as possible my mother was placed in a nursing home in Sebastopol wehre she remained until last week, approximately one year. This year was devastating for the entire family. There are no words to describe to you the feeling of utter helplessness when faced with yet another facility which should never be allowed to exist. This is truly a warehouse for invalids. They dressed my mother in the morning and tied her into a Geri chair, where she remained for the rest of the day -- every day. The only way my mother could move this chair was by bouncing her little 94-lb. body, and this would propel the chair. I have found her numerous times down a short, dark hallway, facing into a corner, crying, unable to turn the chair around, and she possibly had been there for hours. The rails on the Geri chair were always so grimey my hands would stick to them when I went to remove her. If the family wasn't there for two or three days, she would be unable to walk when we took her out of the chair. My husband asked three different nurses on the day shift if my mother could walk, and they told him they **DID NOT KNOW**. My mother paid over $1900 per month for a three bed ward in this snake pit. At dinner time I have witnessed my mother dipping her sandwich into a cup of soup, placing the sandwich and fingers into her mouth, with dried feces all around her fingernails, under her fingernails, and dried to the knuckles on her hand. She had a large toenail surgically removed after being torn backward and almost severed from her large toe. I was never notified. The only explanation I could ever get was that she had droped a cereal bowl on her foot. The podiatrist who did the removal did not know how it had happneed.

The charge nurses seldom ever would leave the nurses station and could not be bothered to assist patients. In every instance I witnessed, they would always call an overworked, underpaid Aide, and the patient had to wait, no matter what the problem, until the Aide could respond to their needs.

One afternoon I was unable to visit my mother so I telephoned the charge nurse and asked her to tell my mother that I would see her the following day. This nurse assured me that she would convey my message. (This is all my mother lives for -- our time with her -- as we are the only constant thing in her life that she remembers.) The following day this same nurse told my daughter that she was just amazed that I would do this because **"your Grandmother doesn't know anything."** My mother is a very sweet, loving lady who has not much memory, but has been relegated to the dark areas of insanity by persons such as this so-called nurse, who should never be allowed to work with, around, or for our helpless elderly.

The Director of Nurses at this facility was caught discussing my mother's personal medical records information with a total stranger, simply because he asked.

The grandchildren finally refused to visit this facility and see their grandmother subjected to such treatment and living in such squallor for nearly $2000 per month. The charge nurses were, for the most part, rude to all of us, and sometimes downright nasty. The Aides worked hard, for the most part, and were kind and good to the elderly, but simply could not handle 70 people by themselves. This facility was cited by the State of California for several violations recently, but a slap on the wrist only momentarily slows the dollar-generating machine.

Laides and gentlemen, can you visualize having to suffer these conditions, or having to place your mother or your loved one into situations such as I have, or having to pay so much for these indignities. I was ill equipped to handle this when it happened to me and feel terribly helpless about changing this system and making this industry be accountable to those of us who have no choices.

Nurse Ratchett lives and seemingly she lives across this land. Our elderly depend on us, and I am afraid it is very much a false sense of security.

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN
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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

May 13, 1986

Ms. Toby S. Edelman
Staff Attorney
National Senior Citizens' Law Center
Suite 400, 2025 M Street, N.W.
Washington, D.C. 20036

Dear Ms. Edelman:

I am writing to confirm your participation as a witness in a hearing of the Special Committee on Aging on the subject of "Nursing Home Care: The Unfinished Agenda".

I am requesting that your testimony answer the following questions concerning the decision of the 10th Circuit Court of Appeals in Smith v. Heckler:

1. What were the plaintiff nursing home residents alleging?

2. Which of these allegations were upheld by the ruling of the 10th Circuit Court?

3. What specific changes in the Federal nursing home survey and certification system are necessary to meet the mandate of the Federal court?

4. What are the implications of the Court's ruling for the Department of Health and Human Services' management of the Federal Medicaid program?

5. Has the Department of Health and Human Services proposed reforms adequate to fully and substantively respond to the mandate of the court in Smith?

Your oral testimony should be no more than five minutes in length, but you may submit more extensive remarks in writing for the record for up to a month after the hearing. The hearing will take place in room SD-628 of the Dirksen Senate Office Building, commencing at 9:00 a.m. on Wednesday May 21, 1986. It will be most helpful if you will provide the Committee with 100 copies of your oral testimony, together with an equal number of any attachments or exhibits you may wish to provide, by close of business on Monday, May 19, 1986.

On behalf of the Members of the Special Committee on Aging, I would like to extend our appreciation to you for your time and effort in preparing for this hearing. If you have questions regarding the hearing or your testimony, please contact Mr. David Schulke or Mr. James Michie of the Committee staff at 224-5364.

I look forward to hearing from you.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:dgs

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Center for Health Law Studies

May 14, 1986

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate
G-33 Dirksen Building
Washington, D. C. 20510

Dear Senator Heinz:

I am submitting the enclosed paper to the U. S. Senate Special Committee on Aging at your request as communicated to me by Mr. David Schulke of your staff.

I appreciate the opportunity to present my research to the Committee. The experience of the states over the past ten years with intermediate sanctions for the enforcement of nursing home standards will assist in the formulation of an effective federal policy and statute.

My research and analysis has appeared in print previously. The two major articles are State Regulation of Long-Term Care: A Decade of Experience with Intermediate Sanctions, 13 Law, Med. & Health Care 173 (1985) and Nursing Home Receiverships: Design and Implementation, 24 St. Louis University Law Journal 681 (1981, Symposium on Nursing Home Law). The article on intermediate sanctions was based on a paper I did for the Institute of Medicine of the National Academy of Sciences for their recent nursing home project. I have also co-authored a book that includes two chapters that examine litigation arising under state enforcement of nursing home standards: Johnson, Terry and Wolff, Nursing Homes and the Law: State Regulation and Private Litigation (1985 Harrison Co., Norcross, Ga.).

Sincerely,

Sandra H Johnson

Sandra H. Johnson
Professor of Law

SHJ:sam

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SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Center for Health Law Studies

May 14, 1986

To: Senator John Heinz
Chairman, U.S. Senate Special Committee on Aging

From: Sandra H. Johnson
Professor of Law and
Assistant Professor of Law in Internal Medicine

I. The Case for Intermediate Sanctions for Enforcement of Nursing Home Standards

Closing a substandard facility is not necessarily an indication of successful enforcement of standards. Rather, in some cases it is a sign of failure because it may disrupt the lives and injure the health of the residents and their families and may aggravate a shortage of nursing homes, especially those certified for Medicare/Medicaid reimbursement. The sanctions of decertification and license revocation, which result in the closing of the substandard facility, pose a threat of serious economic harm to the owners of the facility as well. Required procedures for these sanctions are time-consuming, often delaying enforcement for several years and making heavy demands on the enforcement agencies' limited survey and legal resources.[1] Finally, these penalties are appropriate only for seriously deficient facilities. They are not at all useful, therefore, in enforcing many existing standards.

In light of these limitations, it is not surprising that decertification and revocation are only rarely used.[2] What is needed for the effective enforcement of nursing home standards, then, is an array of enforcement tools that adequately relate the severity of the sanction to the severity of the violation. These more responsive sanctions create

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disincentives for violations because they can be imposed quickly and efficiently.[3]

More than a decade ago, many states reacted to the ineffectiveness of license revocation by revising state licensing statutes to include a variety of intermediate sanctions.[4] The aggregate experience of the states in using these sanctions confirms their contribution to an effective enforcement process. The federal government will benefit from this experience in developing its own intermediate sanctions.

These sanctions will enhance the ability of the federal government in its enforcement of standards in relation to facilities it certifies directly and to facilities found out of compliance in look-behind surveys.[5] Federal intermediate sanctions, which will be utilized by the state Medicaid agencies, can assist state agencies that do not have effective sanctions in their licensing statute or are hampered by defects in the statutory structure of the sanctions that are available to them. Intermediate sanctions adopted by the federal government may be effective in enforcing standards across state lines, in relation to multi-state providers, in a way that is not available to the states.

Although there is disagreement over the appropriate role for the federal government in regulating long-term care, the assurance of quality care and enforcement of sanctions cannot be controlled solely by the states. The federal government owes the taxpayers an acceptable level of supervision over the quality of the product received for its nursing home expenditures. The federal government, as a third-party payor, must seriously enforce quality and quantity requirements. Federal participation in enforcement prior to decertification also allows a coordinated approach between federal and state governments. Moreover, states are subject to political pressures by local legislators, judges and other groups. State enforcement budgets are more vulnerable to political manipulation spawned by the agency's actions in a particular case.

Regulation of the quality of care in the nation's nursing homes cannot be left entirely to the market, either. Market forces will not drive providers of poor care from the market or reward providers of good care unless there is consumer choice. In the context of nursing homes choice is substantially weakened. Once the factors of source of pay (if public pay) and level of care are applied the number of facilities actually available to a particular individual may be very small. The capacity for choice is also limited by the short time available for choosing a facility and the stress accompanying the placement.[6] In addition, nursing homes do not operate in a purely competitive market.[7] While competition may exist for the more "desirable" residents, typically private-pay residents requiring little supportive care, the market does little to protect the nursing home resident who requires a higher level of federally supported care.

II. Recommendations for Intermediate Sanctions

The federal government should adopt those intermediate sanctions that have proven successful among the states and that will increase the flexibility of the government in its enforcement efforts. In particular, the federal government should adopt civil fines and receivership and should further develop the capacity to suspend admissions. The experience of the states indicates that the structure of the intermediate sanctions affects their usefulness. The following discussion briefly analyzes these structural issues.[8]

A. Intermediate Sanctions and Classification of Violations

Implicit in the development of intermediate sanctions is the assumption that the severity of sanctions must relate to the seriousness of the violations. In the typical classification system, Class A violations are those that threaten death or serious injury to residents, Class B are those that may seriously affect the welfare of the residents, and so on. Sanctions relate to the classification of the violation. Sanctions as severe as revocation may be available for Class A violations only, for example. Classification of violations according to seriousness makes the relationship between violation and penalty more predictable and enhances the deterrent effect of the sanctions.

A classification system does not adequately account for the severity of deficiencies and their impact on the health and safety of nursing home residents, however, unless it allows specific violations to move up the scale in light of the facility's pattern of deficiencies, repetition of particular violations and other underlying problems such as insolvency or bankruptcy. Authority to weigh these factors only in the assessment of the amount of a fine is not sufficient if the range of fines available for a particular class of violations is narrow or if the classification system is used to trigger the availability of other sanctions, such as receivership.

B. Civil Fines

Among the most effective of the intermediate sanctions are civil fines. With an appropriate range, the amount of the fine can be sensitive to the severity of the particular violation and the history of the facility. Unlike other sanctions, civil penalties can be swiftly enforced, unencumbered by lengthy litigation delays.[9] To the extent that substandard care is economically motivated, civil fines can increase the cost and decrease the benefit of undesirable behavior. Of course, where a violation is attributable to the poor financial condition of a facility or to a management incompetent to avoid violations, civil fines alone cannot change the prohibited behavior. In conjunction with other enforcement sanctions, however, the imposition of civil fines even in these cases can increase pressure on the facility to make fundamental financial or management changes.

The most serious threat to effective implementation of a civil fine system is persistent, systemic delay, which may occur if the civil penalty system is not well-designed. Delay in enforcement increases costs, requiring the agency to monitor the continued existence or correction of violations and to assign surveyors and their supervisors as witnesses in several proceedings. Long contests consume legal services, a resource often scarce to a state agency.

If the agency abandons enforcement of a large portion of contested fines due to these costs, the agency decreases the risk facilities assume when violating standards and rewards facilities that invest in contesting fines. Abandonment of fines demoralizes agency personnel as well.[10]

Judicial proceedings require the investment of legal services and may take two years or more from the time of filing to the time of the trial itself.[11] While state agencies complain about judges who refuse to impose sanctions once a violation has been corrected even when the statute authorizes such a penalty, providers fear the emotional reaction of an anti-nursing-home jury to lists of deficiencies. It is not simply a coincidence that the most enthusiastic supporters of civil penalty systems report that they rarely, if ever, have a fine appealed to court.

Although access to judicial appeals should not be limited unreasonably, statutory or regulatory structures that actually encourage litigation should be avoided.

An informal conference within the enforcement agency itself can resolve many disputes over fines. During this informal conference, the facility can present facts that mitigate the citation or fine and the agency can modify the fine where appropriate.

Appeal beyond the informal conference to a full administrative hearing allows a more formal presentation of the facts by both sides and review by an administrative judge or hearing officer. This hearing must produce a record so that, if the administrative judge's decision is appealed, it may be reviewed on the record alone. This policy avoids duplication of efforts between the courts and the administrative system and contributes to the swift resolution of disputes.

Although there must be a steady level of enforcement and oversight over all facilities, it is clear that more serious or habitual violators and facilities in serious decline warrant the closest attention. Enforcement agencies and providers agree that the agencies should aggressively enforce regulations against the "bad guys" in the industry, those that consistently provide substandard care. Most state statutes provide for amplified penalties against repeated violations; this is critical to the success of a civil penalty system.

Most civil penalty systems allow a facility to avoid a fine for less serious violations if the facility corrects the deficiency or submits a plan of correction to the agency. While this provision is desirable in that it focuses on correction rather than penalty, it is unjustifiable if the violations have been repetitive. Fines assessed on a daily basis for an uncorrected violation are not as effective as treating an uncorrected violation as a repeated violation thereby multiplying the original fine, because the costs of the required daily or weekly verification of a continuing violation are high.

C. Receivership

The receivership is a powerful tool for the protection of the health and safety of nursing home residents. It has proven effective in protecting residents from injury due to precipitous transfer or drastic deterioration of care in a seriously substandard facility. Agency personnel experienced with receiverships report their effectiveness both as a threat to facilities that have not responded to other sanctions and as a method to provide for the safe and humane transfer of residents from a facility that is closing. The potential of the receivership for improvement of a facility has not been adequately tested, but thus far has enjoyed some success.[12]

Relative infrequency in the use of receiverships is attributable to several factors. First, the receivership is used only in the more serious situations. Second, because it is generally inadvisable for the agency to serve as receiver, the states try to use private receivers, who may be difficult to attract. Third, the cost of a receivership may exceed the income of the facility due to the facility's poorly managed financial structure, predatory contractual arrangements, or costs associated with the receivership such as compensation for the receiver or special reporting requirements set by statute or by the court. Finally, many state agencies are unfamiliar with the effective use of receiverships.

Nevertheless, without question receiverships should be included among the federal intermediate sanctions. Statutory provisions, administrative practices, and effective use of the court's equitable power to fashion the receivership to meet the needs of the facility, the receiver and other interested parties can increase the effective use of receiverships.[13]

A system that allows a receivership only in cases in which the license is revoked or denied or the facility is decertified is too narrow. If one argues that receiverships are reserved for situations in which the continued existence of the facility is in jeopardy and the residents are in danger of precipitous transfer, restricting the receivership to these grounds prevents the use of the receivership in similar situations such as insolvency. Even though decertification or license revocation may eventually occur in these cases, the process is so lengthy that the residents may suffer significant harm in the meantime. The receivership also has the potential to upgrade the quality of some facilities, thereby redeeming them for the marketplace. This goal cannot be accomplished if the statute allows a receivership only when the facility has deteriorated to the point of closing.

The use of a private party as receiver increases the likelihood of success. To some extent, the reluctance of qualified private parties to undertake a receivership arises from fear of the unknown. Detailed documentation of successful receiverships, especially from the receiver's perspective, could encourage the use of receiverships, the participation of private receivers, and the improvement of the receivership process. Of course, the most important tasks in attracting private parties to serve as receivers are to provide the necessary financial resources and to define clearly the scope of the duties of the receiver.

The financial requirements of the receivership may exceed the income of the facility. The most effective funding mechanism for filling the gap between income and expense during the receivership is a governmental revolving or set-aside fund designated for receiverships. The advantage of this type of fund is that it is easily and immediately accessible.

Absent a specially designated fund, the necessary resources could be acquired from expedited Medicare and Medicaid reimbursement, a temporary increase in reimbursement rate, or an advance on reimbursement to be recouped from the facility's assets at the termination of the receivership. If the purpose of the receivership is to transfer residents safely and close the facility in an orderly fashion, the statute should require the owner to post a bond or should establish a lien against the facility for any deficit. This financial support by the facility itself simply fulfills the legal requirement in most state statutes that residents be transferred only in a planned manner.

No matter what the purpose of the receivership, the state agency or the receiver should fully inform interested groups and individuals of the conditions leading to the receivership, its scope and term, and the exact function of the receiver in this instance; that is, whether the receiver is to transfer the patients or maintain the facility for possible purchase. If the receiver has indicated that he or she will not consider becoming the permanent operator of the facility, that should be communicated clearly so that unreasonable expectations do not arise. If the purpose of the receivership is the transfer of the residents, the receiver and the agency should have a concrete and detailed transfer plan in place early in the receivership.

Honest and constant information to employees also is essential. Fully informed employees are better able to assist in supporting the residents' needs. While the facility probably will be reducing employees over this period, it would be harmful if employees left en masse. In addition, employees who are hostile to the home and under the stress of losing their jobs may displace this hostility and stress onto the residents. To avoid these problems, the receiver should develop a specific plan for relocation or job search assistance for the employees. The employees' unions, if any, should be considered parties interested in the receivership for purposes of information and planning.

No matter what the purpose of the receivership, it is ill-suited to long-term existence. If there is no plan for termination, however, it is likely that the receivership may extend beyond its optimum lifespan due to inertia or pressure from groups opposing closing the facility. The statute should establish a limit on the term of a receivership that allows the receivership sufficient time to achieve its goals.

D. Suspension of Admissions

HCFA and the state Medicaid agencies have statutory authority to suspend payment. This sanction deserves further development.[14] Suspension of admissions could be used effectively in situations of habitual, significant violations.

Suspension works well because it combines a de facto fine with adverse publicity and prevents new residents from "settling in" to the facility. Except in truly life-threatening situations, allowing current residents to remain in the facility recognizes that the injury caused by substandard care may be outweighed by the injury caused by transfer. The financial impact of a total suspension is significant, of course, but its economic impact is cumulative over time. While attrition at a long-term care facility occurs at a significant pace, it is not so rapid that a suspension immediately bankrupts the facility; rather, the financial penalty of a suspension increases over time. Suspension of admissions is properly an emergency power, which can be implemented without a prior hearing.

III. Conclusion

This paper has only briefly addressed the structural issues of three major intermediate sanctions. Others should receive serious consideration by the Committee as well. These include emergency powers to intervene when there is a severe threat to the health and safety of residents,[15] public monitors who can be placed at a low cost in substandard facilities to provide closer supervision of the quality of care,[16] and the statutory private right of action, through which residents themselves can enforce standards in civil litigation.[17]

The effectiveness of intermediate sanctions in enforcing standards has been demonstrated in the experience of the states over the past decade. Intermediate sanctions achieve a fundamental fairness in enforcement as well because the premise underlying their structure is that the severity of the sanction should fit the severity of the violation. These sanctions offer the enforcement agency an alternative to closing the facility and create effective disincentives for violations. Because the inspection process is limited in its ability to monitor the compliance of each facility at all times, an enforcement system that effectively deters violations is essential.

Endnotes

1. "Special funds are not set aside at the federal level for regional legal staff or legal actions... When states take court action, 13 have staff attorneys to represent them; 31 have departmental attorneys available; 3 have none." Institute of Medicine, Improving the Quality of Care in Nursing Homes (National Academy Press, 1986) at 169.

2. IOM, supra note 1, at 155.

3. "Research into deterrence consistently identifies the speed and certainty with which sanctions follow upon a violation as being a key to deterrence." Jost, Enforcement of Quality Nursing Home Care in the Legal System, 13 Law, Medicine & Health Care 160, 161 (1985).

4. For a survey of intermediate sanctions see A.B.A. Commission on Legal Problems of the Elderly, Model Recommendations: Intermediate Sanctions for Enforcement of Quality Care in Nursing Homes (A.B.A. 1981); for analysis of litigation arising under intermediate sanctions see Johnson, Terry and Wolff, Nursing Homes and the Law: State Regulation and Private Litigation (Harrison Co., 1985).

5. IOM, supra note 1, at 164.

6. See generally, Hawes, Quality Assurance in Long-Term Care: Major Problems and Issues (1983) at 1 (Briefing Paper for the Institute of Medicine).

7. Rango, N. Nursing Home Care in the United States: Prevailing Conditions and Policy Implications, New England Journal of Medicine 307 (14): 883, 884-85 (Sept. 30, 1982); IOM, supra note 1, at 196-200.

8. The states' experience and recommendations for the structure of intermediate sanctions are discussed fully in Johnson, State Regulation of Long-Term Care: A Decade of Experience with Intermediate Sanctions, 13 Law, Medicine & Health Care 173 (1985).

9. Johnson, et al., supra note 4, at 10-14.

10. See generally, Christianson, J. B., Long-Term Care Standards: Enforcement and Compliance, 4 Journal of Health Politics, Policy, and Law 414 (1979).

11. See, e.g., Commission on California State Government Organization and Economy, The Bureaucracy of Care: Continuing Policy Issues for Nursing Home Services and Regulation (1983) at 155.

12. Significant improvement in seriously substandard facilities as a result of receivership is discussed and analyzed in Johnson, Nursing Home Receiverships: Design and Implementation, 24 St. Louis University Law Journal 681 (1981) and Doty, P., Sullivan, E. H., Community Involvement in Combatting Abuse, Neglect, and Mistreatment in

Nursing Homes, Milbank Memorial Fund Quaterly/Health and Society 61(2): 222, 234 (1983).

13. IOM, supra note 1, at 166-168.

14. IOM, supra note 1, at 165-166.

15. IOM, supra note 1, at 168.

16. Johnson, State Regulation of Long-Term Care: A Decade of Experience with Intermediate Sanctions, supra note 8, at 180-181.

17. Johnson, Terry and Wolff, supra note 4, at 21-28; Hoffman and Schreier, A Private Right of Action Under Missouri's Omnibus Nursing Home Act, 24 St. Louis University Law Journal 661 (181); Stiffelman v. Abrams, 655 S.W.2d 522 (Mo. 1983).

JOHN HEINZ PENNSYLVANIA CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

May 16, 1986

Mr. Robert G. Gates
Director
Department of Health Services
County of Los Angeles
313 N. Figueroa Street
Los Angeles, Cal. 90012

Dear Mr. Gates:

As Chairman of the Special Committee on Aging, I am writing to request your assistance in the Committee's ongoing investigation into abuses and substandard care in nursing homes.

I very much appreciate the generous and invaluable cooperation and assistance that your Department's Health Facilities Division has extended to Committee staff in preparation for a public hearing. Please accept my congratulations and commendation for the very impressive accomplishments of the Health Facilities Division in protecting the health and safety of nursing home residents in Los Angeles County.

It would be most helpful to the Committee if you could permit Mr. Ralph Lopez, Chief of the Health Facilities Division, to testify at our hearing on the morning of May 21, 1986 in Washington, D.C. I have taken the liberty of forwarding to him a request for his appearance and testimony. Please find enclosed a copy of that invitation. I have also informed Senator Pete Wilson, a Member of the Aging Committee, of my invitation to Mr. Lopez.

The hearing will conclude before noon on May 21, which would allow Mr. Lopez to return home on that same afteroon. Should you have any questions regarding my request, please contact Jim Michie or David Schulke of the Committee staff at (202) 224-5364.

Thank you for your cooperation and assistance in this important matter.

Sincerely,

JOHN HEINZ
Chairman

JH:jfm

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

May 16, 1986

Mr. Ralph Lopez
Chief, Health Facilities Division
Department of Health Services
County of Los Angeles
313 N. Figueroa Street
Room 317
Los Angeles, Cal. 90012

Dear Mr. Lopez:

As Chairman of the Special Committee on Aging, I am writing to request that you appear before the Committee on the morning of May 21, 1986 to share with us your experiences in combatting abuses and substandard care in nursing homes.

Committee staff has informed me of your excellent cooperation during our ongoing inquiry into existing regulation and law for providing adequate care to nursing home residents. I was most interested to learn of your close association with law enforcement authorities in seeking compliance by nursing homes with State and federal standards and requirements.

The County of Los Angeles, and especially the County's Department of Health Services, are to be highly commended for providing this kind of protection to nursing home residents. I am hopeful that your testimony will serve to encourage other jurisdictions to follow your example.

I found your evidence-gathering technique of videotaping conditions in nursing homes to be most effective. I believe Jim Michie of the Committee staff has discussed with you our wish to show brief excerpts excluding identifiers of facilities and individuals.

The hearing is scheduled to begin at 9:00 a.m. on May 21, 1986 in room SD-628 of the Dirksen Senate Office Building. I would very much appreciate your providing the Committee with ten copies of your testimony by close of business on May 19, 1986, and an additional 100 copies on May 20, 1986. Your testimony for submission into the record may be whatever length you deem appropriate. The Committee would, however, appreciate your limiting your oral remarks to no more than five minutes.

Mr. Ralph Lopez
May 16, 1986
Page 2

I have also written to Mr. Robert G. Gates, Director of the County Department of Health Services requesting that he permit you to appear before the Committee for testimony. Should you have any questions regarding the hearing, please contact Mr. Michie or David Schulke of the Committee staff at (202) 224-5364.

Again, thank you for your cooperation and assistance in this important matter.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:jfm

ahca
American Health Care Association 1200 15th Street, Washington, DC 20005 (202) 833-2050

May 27, 1986

The Honorable John Heinz
Chairman
Special Committee on Aging
SDG 33 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Heinz:

Last Tuesday evening, while waiting for a flight in the Salt Lake City airport, I was greeted by NBC News' portrayal of your recent committee hearing. That hearing was the first time that I, or anyone in the nursing home industry, was provided the information conveyed in the committee report. My disappointment is less in your failure to provide us with the elemental courtesy of advance discussions. But more that, in not having the opportunity, we were unable to help you avoid the fatal methodological flaws which have rendered your report so misleading.

I find it incongruous that, on the one hand, you characterize the existing survey and certification system as being inadequate to the task of truly judging the quality of care provided in America's nursing homes. Yet, at the same time, you use the data generated by that system to castigate an entire industry. The system either is or is not up to the task of measuring quality of care. We can't have it both ways.

But even were one to accept such a contradictory approach to the survey system and use it as a data base reflective of the industry, the irresponsible manipulation of that data is so appalling as to make the report and its conclusions irrelevant to public policy.

The suggestion that one-third of the nation's skilled nursing facilities are substandard (1,000 of them chronically so) does a disservice so extreme as to question the motivations of those who would perpetuate it. Certainly the data base cannot be used to support such irresponsible allegations. As you know, Mr. Chairman, the nursing home conditions of participation contain some 541 separate and discrete elements. It is more than possible to be out of compliance with one or more of those individual elements, even within what were characterized as "critical" health and safety standards by the report, and still be providing excellent care. Only manipulation of the data by application of the concept "full compliance" would allow one to paint the bleak picture portrayed in the committee report. Failure to comply, on even one occasion, with the paperwork required on a nursing shift could be cited as a deficiency preventing "full" compliance with the 24-hour nursing service standard. Does that deficiency imply poor quality nursing care during that shift? Of course not. Does it reflect the absence of nursing coverage as you suggested during the hearing? Equally unlikely. Yet those appear to be conclusions you would have the American public draw.

A non-profit organization of proprietary and non-proprietary long term health care facilities dedicated to improving health care of the convalescent and chronically ill of all ages. An equal opportunity employer.

This is perhaps my greatest sorrow, Mr. Chairman. The nursing home industry has come a long way from what, admittedly, were difficult times. Every credible analysis, including the recent study by the National Academy of Sciences, clearly points to that progress. This is critical. America's elderly need to have confidence in their community nursing homes. Neither they nor we are well served by gross misrepresentation. To what purpose that shiver of fear periodically visited upon America's elderly? Many of the recommendations in your report are strong enough to stand on their own merits. Is it not irresponsible to color the debate by suggesting that the isolated event is the prevalent state of affairs?

We are not an industry devoid of problems, Mr. Chairman. There are nursing homes providing substandard care. The American Health Care Association supports fair yet effective enforcement mechanisms to deal with them. Our support has extended to intermediate sanction regulations, patient oriented survey systems, a strengthened ombudsman program, and the list goes on. We have further suggested, however, that Congress might well choose to look at the root cause of many of the problems that exist in this industry. Would that you were to focus as much attention on those causes as you do on the symptoms. No provider should work in this industry if not capable of providing at least minimal standards of care, no matter how inadequate the reimbursement. Indeed, few providers in this industry are satisfied at providing only minimally acceptable levels of quality. Yet, given the inadequacy of reimbursement in so many states and Congress' unwillingness to address that issue, minimal becomes the norm. I have seen little attention devoted by the Congress to addressing the adequacy of financing for institutional long term care. Or does it believe that $30 is sufficient reimbursement for a day of high quality skilled nursing care?

We are not so naive, Mr. Chairman, as to suggest that reimbursement is a sufficient condition for high quality care. Hopefully, you are equally willing to recognize that it is, however, a necessary condition. We can continue to engage in expose. We can continue to tinker with the enforcement systems. We can continue to portray in vivid detail isolated horror stories that none of us can or should defend. Or, we can recognize the enormity of the problems facing the nation. We can confront the realities of a demographic tide on a collision course with reduced public funding and work together in an attempt to solve the problems of long term care in this country.

For my part, Mr. Chairman, I choose the latter.

Sincerely,

Paul Willging

Paul R. Willging, Ph.D.
Executive Vice President

PRW:ymm
86284.01

cc: Arnold Renschler
Manor Health Care, Inc.

JOHN HEINZ, PENNSYLVANIA, CHAIRMAN

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DIANE LIFSEY, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

June 10, 1986

Mr. Leland B. Harris
Deputy District Attorney in Charge
Nursing Home and Dependent Care Section
Los Angeles County District Attorney's Office
Hall of Records, Suite 780
320 West Temple Street
Los Angeles, Cal. 90012

Dear Mr. Harris:

As Chairman of the Special Committee on Aging, I am writing to thank you for your invaluable assistance in the Committee's May 21, 1986 hearing on "Nursing Home Care: The Unfinished Agenda."

The videotape of shocking conditions in several nursing homes in Los Angeles County provided very startling evidence of the fact that there is, indeed, much left to be accomplished in protecting nursing home patients from abhorrent abuse and neglect.

I deeply regret that you were unable to attend the hearing and to represent the Nursing Home and Dependent Care Section of the Los Angeles County District Attorney's Office. I am very pleased to inform you, however, that the showing of excerpts from your videotape at the hearing served to indelibly underscore the critical need for strengthening nursing home regulation and patients rights.

On behalf of the Committee, I commend you for the exceedingly excellent and pioneering work that you and your Section are performing in the interest of human decency and justice. Your activity and dedication in this regard should serve as an example for all district attorney offices across America to follow.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:jfm

American
College
of Health
Care
Administrators

June 17, 1986

The Honorable John Heinz
Chairman, Special Committee on Aging
SDG 33 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Heinz:

I am writing to you today in response to the Special Committee on Aging's recent report on the nursing home industry and the subsequent media attention which that has prompted. The American College of Health Care Administrators is a professional society that was founded 24 years ago to enhance the quality of patient care through the education and professional development of the long-term care administrator. It will interest you, I am sure, to know that at the 20th Annual Convocation of the American College of Health Care Administrators which concluded recently in San Diego, California, our Board of Governors passed a resolution reaffirming our organization's commitment to quality care. I have enclosed a copy of that resolution.

During the course of the last year, the College has worked extensively with the Health Care Financing Administration (HCFA) in supporting the new Long-term Care Survey, formerly known as PaCS. For as long as I can remember, professional administrators have begged to have their facilities judged by the quality of care they deliver and not by paper compliance or written documentation of compliance with state and federal regulations. The new survey tool that has been developed by HCFA clearly takes a major step forward in ensuring quality of care to nursing home patients and residents.

The College has been active in other areas of quality assurance as well. We have developed national standards of practice for nursing home administrators which define acceptable procedures for providing quality care to nursing home patients and residents. Our Standards of Practice, by action of the Pennsylvania legislature, will be used as objective and measurable guidelines by the Licensure Board. It is our firm hope and desire that these Standards of Practice will be used by state licensure boards when reviewing nursing home administrators. We are constantly developing educational programs which keep professional administrators on the cutting edge of new technologies and management skills required in these ever-changing times of health care delivery. The American College of Health Care Administrators presently offers 42 educational programs with 59 nationally acclaimed experts serving on our faculty.

Through a major grant from W.K. Kellogg Foundation, the College developed a professional certification program for long-term care administrators. This voluntary certification program has been cited as a model for other health professions, in that the program includes measures of both knowledge and skills and comparison of individual results with national standards of competency for professional administrators. Candidates for professional certification assess their knowledge and skills during a three-day examination process; review the results in relation to the national standards of competency; prepare a professional development plan designed to strengthen any areas of weakness; have the plan reviewed by a panel of nationally elected peers and public members; and im-implement the plan over a five-year period. A reassessment occurs every five years. Even those professionals whose knowledge and skills meet or exceed the national competency standards are encouraged to develop a plan to assure that their knowledge and skills are continually updated and upgraded.

The College requires adherence to a Code of Ethics for its membership and has in place a strong self-regulatory system for monitoring and taking action on alleged violations of that Code of Ethics. The Code includes assurance of quality care for those we serve.

Senator Heinz, it is my sincere desire to spread the word of the College and to make this nation's citizens aware of the fact that the long-term care industry is one which is being led by professionals who have affirmed and reaffirmed their commitment to cost-effective quality patient care. It is my opinion that this can best be effected through educational and self-regulatory programs like those offered by the American College of Health Care Administrators.

While I have no doubt that your committee's report on nursing homes was intended to bring about positive change, the media's subsequent attack on long-term care only serves as a source of anxiety to nursing home patients, their families and the families of potential nursing home patients who are in the process of making very difficult personal decisions. Also affected is the morale of the hundreds of thousands of loyal and dedicated nursing home staff members who give so much of themselves to those they care for.

Because of this potentially deleterious effect of the media's representation of your study, it is incumbent on us both to provide information to the public about the educational and self-regulatory programs for professional administrators that assure quality care for our precious elderly. The American College of Health Care Administrators has assembled the largest known library on long-term care in the United States. I would like to take this opportunity to offer this "Informnation Central" and our research services to you. I would also invite you to visit our headquarters in Bethesda to see first hand the commitment of this professional society and its membership to quality care for those we serve. I do hope that you will call upon us.

Sincerely yours,

Mark J. Finkelstein, CFACHCA
President

cc: Board of Governors
Enclosure

American
College
of Health
Care
Administrators

RESOLUTION OF PATIENT CARE:

Board of Governors Meeting
May 27, 1986, San Diego, CA

WHEREAS, the administrators of long-term care facilities are faced with one of the most complicated and consequential assignments in today's society; and

WHEREAS, many people seeking admission to long-term care facilities are more frail and in more serious physical condition than in previous times; and

WHEREAS, regulatory and reporting requirements place increasing, time-consuming documentation demands on administrators; and

WHEREAS, administrators are under increasing pressure to be responsive to varied and splintered segments of society including governmental bodies, consumer groups, third-party payors, regulatory agencies, and others,

NOW THERFORE BE IT RESOLVED, that the American College of Health Care Administrators affirms that patient/resident care is the foremost concern of long-term care administrators. Ensuring the quality of services to the nation's elderly is the paramount responsibility.

BE IT FURTHER RESOLVED, that the administrator will place the health, welfare, safety and happiness of the patient/resident before all other role expectations and dedicate his/her career to achieving quality patient/resident care.

Approved by Board of Governors, May 27, 1986.

Please Note
Our New Address:
8120 Woodmont Avenue, Suite 200, Bethesda MD 20814 • (301) 652-8384

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street, Boston, Mass. 02111

MICHAEL S. DUKAKIS
GOVERNOR

RICHARD H. ROWLAND PH.D.
SECRETARY

June 18, 1986

Senator John Heinz, Chairman
United States Senate
Special Committee on Aging
G33 Dirksen Senate Office
Washington, DC 20515

Dear Senator Heinz:

The Massachusetts Executive Office of Elder Affairs recently completed a series of ten hearings on the Quality of Care in Massachusetts Nursing and Rest Homes. Nine of the ten hearings were scheduled in nursing homes to enable greater access by residents, staff and families. In all, nearly two hundred people provided testimony.

Our findings were very similar to your recent report: Nursing Home Care - The Unfinished Agenda. Additionally, the findings were consistent with those of the Institute of Medicine.

Massachusetts has a reputation for providing good quality of care which was bourne out through your statistics. We do, however, experience problems regarding quality of care and Medicaid Discrimination. We believe that the problems of providing quality of care are directly linked to a lack of well-trained nurses aides and licensed personnel to provide the care.

Enclosed is a copy of our Report as well as copies of two of our bills which are currently being actively considered by the Massachusetts General Court: An Act to Insure the Elderly Equal Access to Long Term Care Facilities Participating in the Medical Assistance Program and An Act Relative to the Training of Nurses Aides.

We have also been working with the Legislature to include an increase in the Medicaid Budget to permit a targeted wage increase for nurses aides. To date, the Senate Ways and Means committee has earmarked ten (10) million dollars for this purpose.

Quality care for elders will never be a realistic goal until the Federal and State Governments work together to identify problems and solutions. We wish to congratulate you and your staff for the comprehensive report, Nursing Home Care -

Senator John Heinz, chairman
June
Page Two

the Unfinished Agenda. It has certainly increased everyone's understanding of the problem. If you or your staff have any questions regarding our report or legislation, please contact me. We are most willing to work with you to improve quality care.

Sincerely,

Richard H. Rowland

RHR/SMcD:RW
Enc.

SENATE . . . . No. 1928

The Commonwealth of Massachusetts

SENATE, May 19, 1986.

The committee on Human Services and Elderly Affairs, to whom was referred the petition (accompanied by bill, Senate, No. 643) of Frederick E. Berry, J. Michael Ruane and Frances F. Alexander for legislation to insure the elderly equal access to long term care facilities; so much of the recommendations of the Executive Office of Elder Affairs (House, No. 74) as relates to insuring the elderly equal access to long term care facilities participating in the medical assistance program (House, No. 85); and the petition (accompanied by bill, House, No. 3561) of David P. Magnani for legislation to insure the elderly equal access to long term care facilities report the accompanying bill (Senate, No. 1928).

For the committee,

JACK H. BACKMAN.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Six.

AN ACT TO INSURE THE ELDERLY EQUAL ACCESS TO LONG-TERM CARE FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 111 of the General Laws is hereby amended by inserting after section 72V the following: —

Section 72W. Each long-term care facility licensed pursuant to section 72 of this chapter and participating in the medical assistance program pursuant to section 18 of chapter 118E shall:

(a) employ an application/inquiry form, on a standard form as established by the department for each admission inquiry;

(b) provide a receipt to each applicant for admission to its facility who requests placement on a waiting list stating the date and time of such request, and the level of care sought by the applicant;

(c) accept all applications at level of care provided by facility;

(d) shall not request the source of payment at the time of application or any time prior to the individual's being accepted at the facility;

(e) maintain a dated list of such applications and placements which shall be available at all times to an applicant, his bona fide representative, authorized personnel from the Department of Public Health, Public Welfare and Elder Affairs, and such other state agencies or other bodies established by state statute whose statutory duties necessitate access to such lists. The inspection of such lists of applicants and placements shall be reviewed periodically by the Department of Public Health and shall be included in the annual survey of long-term care facilities for certification in the medical assistance program; and

(f) admit patients in the sequence as they appear on the waiting list as maintained by that facility.

Section 72X. The admission by a long term care facility, subject to section 72W of this chapter of a privately paying applicant before the admission of an applicant who is eligible for or receiving medical assistance under chapter one hundred eighteen of the General Laws, and whose name appears earlier on the waiting list than the said, private pay applicant shall create a rebuttable presumption of discrimination made unlawful herein. The provisions of subsection (f) of section 72W may be waived, upon the request of a facility, when the department determines that an emergency placement is necessary to protect the life, health, safety, or welfare of an applicant.

The department in conjunction with EOEA and after public hearing shall promulgate rules and regulations defining extraordinary circumstances, if any, under which the provisions of subsection (f) of section 72W may be waived.

Section 72Y. Violation of sections 72W or 72X shall be punished by a fine of not less than two thousand dollars per occurrence. More than one violation of sections 72W or 72X by a long-term care facility during a calendar year shall constitute grounds for the renovation of the certification of participation of such facility in the medical assistance program.

SECTION 2. The definition of the term "resident" in Section 27, Chapter 19A of the General Laws, as inserted by Chapter 544 of the Acts of 1983, is hereby further amended by inserting after the words "long-term care facility" the words: —

and any applicant for admission to a long-term care facility

SENATE . . . . No. 1879

The Commonwealth of Massachusetts

SENATE, May 7, 1986.

The committee on Health Care, to whom was referred so much of the recommendations of the Executive Office of Elder Affairs (House, No. 74) as relates to the training and certification of nurses aides (House, No. 84), report the accompanying bill (Senate, No. 1879).

For the committee,

EDWARD L. BURKE.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Six.

AN ACT RELATIVE TO THE TRAINING OF NURSES AIDES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 111 of the General Laws is hereby amended after Section 72V by adding the following new sections:

Section 72W. The following definitions shall apply to sections 72X and 72Y:

"Nurses aides," any person who provides nursing care under the supervision of a nurse for the purpose of providing safety, comfort, personal hygiene or protection of a patient in a facility licensed pursuant to this chapter.

"Long term care facility," a convalescent home, nursing home, rest home or charitable home for the aged licensed under the provisions of Section 71 of this chapter.

"Nurses aide training program," a program providing a minimum of 60 hours of training approved by the Commissioner. The Commissioner shall establish minimum standards jointly with the Secretary of Elder Affairs and the Board of Registration of Nursing.

Section 72X. The commissioner shall establish jointly with the Secretary of Elder Affairs and the Board of Registration of Nursing minimum standards for the training of nurses aides. Regulations setting said standards shall be promulgated by the commissioner within one year of the effective date of this act.

Section 72Y. Any person administering a long term care facility licensed under the provisions of section 71 who hires a nurses aide shall provide for the training of said nurses aides in a training program established pursuant to section 72X within 90 days. Employees hired as nurses aides prior to the effective date of regulations promulgated to implement the provisions of this act who have not completed a training program must complete said training program within 180 days of the effective date of said regulations.

This Document Has Been Printed On 100% Recycled Paper.

THE EXECUTIVE OFFICE OF ELDER AFFAIRS

A HEARING REPORT

THE QUALITY OF CARE IN MASSACHUSETTS NURSING AND REST HOMES

Michael S. Dukakis,
Governor

Richard H. Rowland, Ph.D.
Secretary

Lillian Glickman, Ph.D.
Assistant Secretary for Programs

Susan McDonough
Long Term Care Ombudsman

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PRIORITY RECOMMENDATIONS

In the Fall of 1985, Richard H. Rowland, the Secretary of the Executive Office of Elder Affairs, convened a series of ten hearings, held throughout the state. The purpose of the hearings was to solicit testimony on the quality of care in nursing and rest homes, and to address the necessity for changes to improve the service provided. More than 600 people attended the hearings and, of these, nearly two hundred presented testimony. In order to increase access to these hearings by residents, the true consumers, nine of the ten hearings were conducted in nursing homes.

These hearings took place during a year in which Massachusetts was spending almost one-half of its total $1.2 billion Medicaid budget, $579 million, on nursing home and chronic hospital care. This figure does not include rest home funding, which is paid out of Supplemental Security Income (SSI).

Nursing home quality of care issues had also attracted significant federal attention. The National Academy of Sciences, Institute of Medicine, had been commissioned by the federal Department of Health and Human Services in late 1983 to prepare a report on health, safety, and staffing in the nation's nursing homes. The report was being completed in the fall of 1985 when the Executive Office of Elder Affairs' (EOEA) hearings took place. When the federal report emerged in early 1986, its major findings coincided with priority recommendations of this report: the needs to improve nurses aides training and to prevent discrimination against Medicaid and/or heavy care patients.

Throughout the EOEA hearings, it was clear that one major issue emerged from the testimony. Nearly half of all the testimony received dealt with the lack of appropriately trained, direct care workers in long term care facilities. Over and over again, people testified that this lack of nurses aides and other direct care staff was a direct result of low wages paid to people who care for very old, debilitated people. Comparisons were made between the salaries of nurses aides and those of fast food workers and people who wash cars. While the nurses aides had a clearly more demanding and vital job, they were generally paid far less.

Based on the testimony provided, the Executive Office of Elder Affairs recommends the following changes to improve the quality of care which residents receive:

I. THAT THE SALARIES OF DIRECT CARE STAFF IN NURSING AND REST HOMES BE IMMEDIATELY UPGRADED. THIS RECOMMENDATION TO BE IMPLEMENTED BY AN ADDITION TO THE MEDICAID LINE ITEM OF THE DEPARTMENT OF PUBLIC WELFARE BUDGET UNDER H1 WITH ACCOMPANYING OUTSIDE LANGUAGE STIPULATING THE TARGETING OF SUCH FUNDS TO THE DIRECT CARE WORKERS' SALARY INCREASES.

II. THAT THE STATE LEGISLATURE ENACT A LAW REQUIRING A STANDARDIZED COMPREHENSIVE TRAINING PROGRAM FOR NURSES AIDES. (SEE HOUSE BILL 84: "AN ACT RELATIVE TO THE TRAINING AND CERTIFICATION OF NURSES AIDES.")

As Secretary Richard H. Rowland stated at one hearing: "We cannot expect champagne treatment on a beer budget. If we want quality care and dignity for our loved ones in nursing homes, we have to address the question of standards, training, and salary increases for the people who provide their hands-on-care."

Another issue raised concerns the question of equality of access to nursing home care. Despite Massachusetts law, stories abound of prospective nursing home residents being denied beds because of their heavy care or Medicaid status.

Because this situation continues despite existing law, the Executive Office of Elder Affairs recommends the following steps:

III. THAT THE STATE LEGISLATURE ENACT A LAW PROHIBITING LONG TERM CARE FACILITIES FROM REQUESTING ADVANCE OR ADDITIONAL PAYMENTS FROM MEDICAID PATIENTS OR PROSPECTIVE PATIENTS. (SEE HOUSE BILL 83: "AN ACT TO PROHIBIT ADVANCE PAYMENT AND SUPPLEMENTATION OF NURSING HOME AND REST HOME RATES.")

IV. THAT THE STATE LEGISLATURE ENACT A LAW REQUIRING LONG TERM CARE FACILITIES TO MAINTAIN WAITING LISTS ACCORDING TO THE TIME OF APPLICATION FROM PROSPECTIVE RESIDENTS WITHOUT REFERENCE TO SOURCE OF PAYMENT. (SEE HOUSE BILL 85: "AN ACT TO INSURE THE ELDERLY EQUAL ACCESS TO LONG TERM CARE FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM.")

These are the four priority recommendations from the Executive Office of Elder Affairs to improve quality of care in Massachusetts nursing and rest homes and to guarantee equality of access to this quality care for all elders in the Commonwealth.

OTHER RECOMMENDATIONS

From the testimony provided at the ten hearings, the Executive Office of Elder Affairs further recommends:

1. That a task force be formed consisting of the Executive Office of Elder Affairs, the Department of Public Health, Rate Setting Commission, Medical and Nursing Schools, and the Long Term Care Industry which will address the problems of attracting and retaining appropriate staff in nursing and rest homes.
2. That the Massachusetts Federation of Nursing Homes, the Association of Massachusetts Homes for the Aged, the Department of Public Health, the Executive Office of Elder Affairs, and Advocacy Programs form a committee to discuss the negative image of the industry and develop strategies to address the issues of increased professionalism of workers and a positive image of the industry.
3. That the Department of Public Health conduct a review of the minimum staffing requirements for nursing and rest homes to provide adequate care for the needs of residents, particularly those being discharged from hospitals to nursing homes with increased medical needs under the Medicare Diagnosis Related Groups system.
4. That the Department of Mental Health, the Department of Public Health, and the Executive Office of Elder Affairs form a task force to develop new strategies and regulations to address the needs of the de-institutionalized elders in rest homes.
5. That Area Agencies and Councils on Aging should promote the participation of elders in nursing and rest homes in social and recreational activities available in the community.

FINDINGS

DIRECT PATIENT CARE

The common thread which ran throughout the course of the hearings was quality of care. The care provided by hands-on caregivers was the most frequently mentioned issue for all groups: residents, families, administrators, and advocates, constituting nearly half the testimony received.

While individuals testifying were generally complimentary about the aides who did provide care, the following concerns emerged:

Inadequate Staffing

The lack of nurses aides resulted in residents not being given proper care such as being left lying in their feces and urine for hours, not having restraints released at appropriate intervals, being left in bed all day because of insufficient staff to get them up and dressed, decubitus ulcers forming, cries for assistance going unanswered, and no assistance available to residents who needed to be fed.

Testimony

> Family member: "There are times when they get no change of clothes for weeks until a visitor helped her. Baths were seldom given."
>
> Family member about her husband: "Also, he is mostly changed at dressing time in the morning. So he is wet through in the interval. His trousers reek with urine. Recently at night, they do not put on 'any attends.' Consequently, he is in a very wet bed, and often soiled with feces. His skin is showing this neglect. Often, his bell is not where he can push it. The aides' theme song is 'I'll be back,' which they never do."
>
> From Residents: "They don't have enough help here."

> "The nursing staff is demoralized. There is a constant shortage of adequate personnel. There is too much work assigned. This leaves them bitter, frustrated, and irritable, and the residents are recipients of the above feelings."
>
> "I needed to go to the toilet and it was one hour and twenty minutes before anyone came."
>
> "I did not get my shower this week, not enough aides I guess."
>
> "I don't take a nap. They don't have time to help me to bed."
>
> Family member: "The aides at our nursing home are caring loving human beings who are burning themselves out working double shifts and days without time off, trying to make what days many of these people have left tolerable."
>
> Staff: "My question is, 'Who is going to speak for these people.' Morale where I work is low and it is mainly because of inadequate staffing. Some weekends this past summer, I had 3 aides and myself to care for 41 Level II patients. The nursing supervisors tried their best to get more help but there was no one available. Fewer and fewer women want to work that hard for so little money."
>
> From a nursing home Administrator: "Here in Berkshire County, we are currently experiencing the most severe shortage of nurses aides in memory, and if it is not soon alleviated, it will reach crisis proportion."

Causes of this problem were attributed to:

1. Low Salaries

According to most of the testimony, the average starting wage for a nurses aide in a nursing home was between $3.50 and $5.00 per hour. In the competitive market for unskilled labor, retail stores and fast-food restaurants are attempting to recruit from the same pool, with starting wages of $5.50. Given the type of work required, nursing homes were reported as unable to compete.

Testimony

From a family member: The pay rate for our nursing home help is terrible. A person is paid much more working with stock in a supermarket, than working with our old people."

From a staff person: "I live alone and it takes everything I earn, and other things have to be left unpaid, and undone until I can pay them. I feel we should have medical insurance and higher wages. I love my work, because I love older people; I don't want to give up my job because I love working with older people, even for $3.60."

From a union representative: "It is sad in a society that puts a price tag on everything, that people are paid more caring for lawn, pets, home, appetites, and automobiles than they are caring for our elderly."

From an administrator: "Nursing homes have always been a low wage industry because of the limitations of public financing. We need adequate reimbursement to compete for employees and to compensate people appropriately for the work they do. The level of quality care any facility can deliver is directly linked to the quality of the people who interact with and serve our elderly patients."

From a residents council: "We have been experiencing a high turnover of nurses aides in our home and sometimes a shortage of help. We feel that the major cause of this is that people can get jobs with higher wages and less responsibilities in other lines of work, especially fast food restaurants."

From an Ombudsman: When they can go to a fast food franchise, supermarket, and receive several dollars an hour more, their priority in the job market is not nursing home aides."

2. Image of the Long Term Care Industry

It was generally agreed that the Long Term Care Industry suffers a poor image and this, combined with lack of value attached by society to caring for older people, makes it difficult to attract qualified individuals.

Testimony

> From a staff person: "Generally, when people ask me what line of work I am in, and I tell them that I work in a nursing home, they usually respond by saying 'Isn't that a depressing place to work?' or 'Is that what you really want to do?"

3. No career ladder for unskilled workers in Nursing Homes

While there have been some efforts to establish scholarships for aides to become nurses, most facilities are not in the financial position to offer this as an incentive. Nurses aide jobs are generally perceived to be a dead end, with little hope for advancement.

4. The Department of Public Health's minimum standards for staffing in nursing homes need to be reviewed and changed

Staff of facilities throughout the state commented that the present minimum standards failed to address the needs of the elder entering a nursing home today. There is a trend to admit a much more debilitated, medically-needy resident. With the advent of the new Diagnostically Related Groups (DRGs) System which sets limits on the number of days an elder may stay in a hospital, based on their diagnosis, few elders stay long enough to recuperate fully. As a result, nursing homes will admit residents from hospitals much earlier and these residents will generally be in need of greater nursing requirements.

Training

Staffing problems of another type were determined to have a detrimental effect on resident care. Individuals who lacked the training and the temperament to serve older people were often the cause of poor patient care and, in some instances, abuse.

Testimony

> From a family member: "I think that patients need to get better care in the handling of them. I know that for my mother I can speak for her that she has many scratches and bruises that come about either through carelessness or from not knowing how to handle the patient, especially when the patients are deadweight. They are very heavy. I think there has to be very much more training in that respect."

> From staff: "Added to the fact of low pay, we hate to just "dump" a new person (usually inexperienced) on a unit and have them learn by "on the job training" with no basic classroom instruction. Usually, people giving this type of orientation will not stay long at the facility and then we repeat the process. There is so much more to nursing today than just the basic "bath and back rub" that is behooves us to do the best we can in educating our staff to the best of our ability and giving them a secure feeling that they are doing a good job."

Because there is such a problem in recruiting nurses aides, facilities were often forced to hire people, particularly for the night or weekend shift, who lacked references. As a consequence, aides who might have had an abusive history unknown to the Administrator could be hired to work at another facility on the evening or weekend shift.

> From an Ombudsman: "I'd like to see more training too. I really dislike seeing 16-17 year old girls, barely adults, coming into a nursing home for 3 days' training and then all of a sudden they're left to take care of 5-10 patients and they get very scared."

The lack of permanent staff often results in a heavy dependence upon "pool staff" -- nurses and aides to meet the minimum staffing requirements for the facility. This type of staff has no knowledge of the residents care requirements, medical history, and emotional state. There have been cases reported to the Ombudsman Program and the Department of Public Health of instances of medication being given to the wrong resident.

> From an Ombudsman: "In one home, on the 11-7 shift, a male patient was in a constant state of seizure and the agency person only took his pulse and respiration rate because she knew so little about the patient."

High Turnover Rate

High turnover rates of staff contribute to poor care. Similar to the problem of poor care provided by "pool staff," a constant turnover of direct caregivers confuses residents and undermines the care. It takes patience and understanding to deliver quality care to residents and, if workers do not remain on staff long enough to develop a rapport with residents, the resident suffers.

> From an Advocate: "Emotionally, residents suffer as a result of the high turnover. Personal bonds, often the most tangible possession left to the elderly, are continuously broken. Consider how you would feel adjusting to new faces and personalities in your living room every week."

> From an Ombudsman: "Also, we have residents who ask if the aides are leaving because of something they did. It is very upsetting to the residents to constantly have new people taking care of them every two or three months.

Aides Who Cannot Communicate With Nursing Home Residents

Facilities pressed to meet staffing requirements hire groups of non-English speaking aides for residents whose primary language is

English. As a result, these aides are not able to properly answer call bells or provide patient care. Further, it is very frightening and frustrating for a frail individual to attempt to make their needs known. Serious neglect may result.

> From a family member: "Aides (and nurses) should be able to read and speak the English language. Patients suffer when there is no communication or they are fed the wrong food because they could not read the name on a tray, especially when the food is prepared special for particular patients. It does happen!"

The lack of training, particularly of nurses aides, was the basis of many individuals' testimony. Specific instances of neglect were cited by residents' families and former aides. While in many cases the neglect was serious, most of the testimony was qualified with the fact that it was not the result of malicious behavior, but rather, because of ignorance.

1) There is no requirement that aides receive a basic training program prior to providing patient care.

2) Aides are unaware of the aging process and residents' rights and often provide little protection for residents' dignity.

3) Facilities that provide on-the-job training by placing a new aide with a more experienced aide who may not have received training. Bad habits are thus perpetrated.

4) Many instances of resident abuse could be avoided if aides were trained in the proper procedures to deal with a hostile or combative resident in advance of a crisis situation.

LACK OF QUALIFIED LICENSED PERSONNEL FOR NURSING AND REST HOMES

The testimony of nearly 50 individuals addressed the problem of the lack of licensed professionals willing to serve nursing and rest homes. These licensed professionals included: physicians, nurses, occupational and physical therapists. Similar to the problems associated with recruiting nurses aides, many areas experience great difficulties in attracting licensed personnel as a result of the image of the industry and the nature of the care. For instance, in the City of Boston the competition for registered nurses is acute due to the large number of hospitals which pay higher wages. Conversely, once away from major metropolitan areas, nursing and rest homes are unable to attract physicians. Poor patient care is the result. Several individuals also cited the minimum staffing requirements of the Department of Public Health as a problem.

> From a Department of Mental Health Professional: "I would like to see a staffing pattern with a professional approach to people with special needs in special settings. This is not intended as a criticism of what's being done by people who are operating the few resources under... But I think there's nothing like having on-site people who really know the individual clients available to work with them rather than having to call in somebody at the last minute in a crisis. I think many crises could be averted if special programs were geared to that."

> From Resident's Council: "We also feel that there should be a greater number of medical doctors associated with nursing homes so that residents could have more options in their medical care. We would feel more comfortable if we could choose our doctors rather than have them appointed to us."

> From an administrator: "At present, a nurse is used in rest homes to examine records of medication administration four hours per month. Instead of her looking into the facility itself, she's looking at the record of administration of medication and does not devote any time to anything else there. The requirement should be changed so that they have a nurse on duty one shift per day."

FEAR OF RETALIATION

Preserving the dignity of nursing and rest home residents was the subject of impassioned testimony. Residents testified that being treated with respect and dignity was as important as the food to them. Many of the instances mentioned involved the care provided by untrained workers but did reflect a poor concept of elders and their needs. Ombudspeople related situations where residents were discouraged from attending the hearings by the facility staff. Some staff people who testified stated that many times problems arose from employment of staff with poor attitudes.

As one nurse stated, "I will probably never get work again after this, but the staff there treated those poor people like dogs, making them beg for things." This nurse had also arranged to bring a disabled resident to the hearing to enable him to testify.

Retaliation was mentioned frequently. Most people were reluctant to sign written testimony, give their full name at the hearings or identify the specific facility where they were encountering problems. While very few of these people were actually threatened, the atmosphere of fear was real. Ombudsmen were asked to read testimony in order to keep identities confidential.

Testimony

From a family member: "Just because you reach a certain point and you're either in a nursing home or just because of your age, doesn't mean you have to hold your head down. You can still be old and have illness but not be degraded either.

From a resident's council: "The first thing is the restrictive emphasis on safety which reduces residents' feeling of self-worth; such as not being encouraged to use the elevator to visit friends on the other floors; noise in the facility at night; and wanderers who take others' belongings; and poor laundry services."

From an Ombudsman (speaking about residents): "Some residents are not here. They are afraid of retaliation by those persons who are now responsible for their physical care. Others are not here because they are viewed as less than competent by nursing staff. Others are not here because the importance of this occasion, as an event where residents can gather and share their concerns about their care, has not been communicated to them by responsible and aware nursing home staff."

From a family member: "Patients should be treated with more dignity regardless of their mental or emotional condition. They should have privacy (curtains drawn), when they are bathed. Many patients complain when they are bathed in bed, because they are cold and naked until all bathed."

And finally from a resident: "We need someone to hold our hand, kiss us on the cheek, reassure us, and commiserate with us. Please don't find fault with us, ignore us or scream at us. We are not inanimate objects. Esteem, dignity, and self-respect are important to us. Recognize our needs and desires. Tomorrow, we will be gone."

MENTAL HEALTH ISSUES

De-institutionalized Mental Health Residents

Testimony at hearings near the catchment areas of mental health hospitals indicated that many former residents of mental health hospitals had been placed in rest homes as part of the de-institutionalization effort. The Department of Public Health estimates 30% of the population of rest homes are de-institutionalized. These residents present specific health care needs which most rest homes were unable to meet adequately.

In 1984, the Department of Public Health published a Rest Home Report. Based on a sample, it was concluded that more than 62% of the residents were taking several medications, and another 39% regularly took psychotropic drugs. The current regulations for staffing in rest homes requires only that an untrained responsible person be on duty twenty-four hours per day, and that four hours of nursing services be available per month. Hours for activities and social services are few and do not meet the needs of the residents.

As a result, elders who had been living in the very structured environment of a state hospital are "de-institutionalized" to a rest home and then receive little or no assistance. One person who testified termed it "warehousing." The behavior of these residents generally takes two avenues if they receive no stimulation nor supervision:

1) They withdraw, sitting day after day in their rooms or sitting in smoke filled TV rooms.
2) They exhibit hostile, combative behavior and frighten other residents.

These residents, as the Department of Public Health concluded in its 1984 report, take medications which, if not properly administered, have significant side effects.

One owner of a rest home testified that he had such a high census of de-institutionalized residents that he could not attract elders currently living in the community to seek placement in his facility. He felt that his rest home would soon be 100% de-institutionalized.

Residents of nursing homes who are labeled "behavior problems" do not have equal access to area mental health services. These residents' families are often told they must transfer the residents because they are a danger to themselves or to other residents.

> From a staff person: "Rest homes have only one girl working 3-11 and 11-7. Small rest homes as ours is, has only one girl all three shifts, and to have some of the Worcester State people is very hard. I have been hit over again, almost hit on the head with a phone, sworn at over and over, kicked, and spit on. We can do nothing, but try to calm them down, no one wants them when they do these things. We have no place to send them, the hospital doesn't want them, not even on the mental health floor. What can we do?"
>
> From an advocate: "Fourthly, is the problem created by having residents of state mental facilities entering into nursing and rest homes. In general, the staff of nursing and rest homes are not trained on how to deal properly with these residents. I have seen and heard about the consequences of this problem many times. A resident with a psychological problem is dealt with improperly by a staff member; the staff member is physically abused by residents; and the resident is forced to leave the facility. All of this could be prevented with proper staff training."
>
> From an Ombudsman: "I would like to talk about rest homes and de-institutionalized people. It really has amazed me in the last fifteen days to see so many people who are de-institutionalized. They may have

day care services, otherwise they have no support services and no follow-up. They just go out and wander around the streets. They upset the neighborhood. They upset the people who are in businesses. It's really very sad."

EQUAL ACCESS TO LONG TERM CARE

Although most individuals who testified at the ten hearings were already associated with a specific nursing or rest home as residents, administrators, family members, or Ombudsmen, there was another issue raised in connection with gaining access to nursing home beds.

Heavy care nursing home residents and Medicaid-eligible residents, according to testimony, present difficult placement problems. A light-care, and "private-pay" resident can be given access to a nursing home bed more easily.

Testimony

> Family member: "It's a very difficult process to have a Medicaid patient placed. It's almost next to impossible. He's going to be difficult to place. He's a lot of care and this is basically what my problem is."

> Family member about her father: "Although my parents' story is a sad one, I know it is not unique. My parents were able to live reasonably well on their Social Security benefits for almost ten years after retirement, but as soon as major illness robbed them of their ability to manage and cope with day-to-day survival and made them dependent on the state for their welfare, they were swept up in a vortex of bureaucracy."

> Family member: "My mother would have become Medicaid-eligible in a very few months, given the cost of daily care in the nursing home. I was told that, if I would 'guarantee' payment for the first two years, her chances of being accepted would increase. I did so, and she was accepted very shortly. It has cost me $60,000."

APPENDIX

LONG TERM CARE HEARINGS

On August 20, 1985, the Secretary of Elder Affairs Richard H. Rowland convened the first of ten hearings on the quality of care in nursing and rest homes at the Franklin Nursing Home in Greenfield, Massachusetts. For the first time, hearings on the quality of care in nursing and rest homes were brought into facilities and communities where families, residents, staff, and advocates were able to attend.

August 20, 1985
    Location: Franklin Nursing Home, 329 Conway Street, Greenfield
    Time: 1:00 p.m. to 3:00 p.m.

September 10, 1985
    Location: Pilgrim Manor Nursing Home, 60 Stafford Street, Plymouth
    Time: 10:30 a.m. to 12:30 p.m.

September 13, 1985
    Location: East Village Nursing Home, 140 Emerson Garden Rd., Lexington
    Time: 9:30 a.m. to 11:30 a.m.

September 13, 1985
    Location: Mary Immaculate Nursing Home, Zero Bennington St., Lawrence
    Time: 2:00 p.m. to 4:00 p.m.

September 30, 1985
    Location: Gardner Auditorium, State House, Boston
    Time: 2:00 p.m. to 4:00 p.m.

October 4, 1985
    Location: Keystone Nursing Home, 44 Keystone Drive, Leominster
    Time: 10:00 a.m. to 12:00 p.m.

October 4, 1985
    Location: Maples Nursing and Retirement Center, 20 Common St., Wrentham
    Time: 2:00 p.m. to 4:00 p.m.

November 7, 1985
    Location: Berkshire Hills North Nursing Home, 190 Prospect St., Lee
    Time: 10:30 a.m. to 12:30 p.m.

November 21, 1985
    Location: North End Community Nursing Home, 70 Fulton Street, Boston
    Time: 9:30 a.m. to 11:30 a.m.

November 26, 1985
    Location: Lutheran Home for the Aged, 26 Harvard Street, Worcester
    Time: 2:00 p.m. to 4:00 p.m.

HOUSE . . . . No. 83

Accompanying the ninth recommendation of the Executive Office of Elder Affairs (House, No. 74). Human Services and Elderly Affairs.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Six.

AN ACT TO PROHIBIT ADVANCE PAYMENT AND SUPPLEMENTATION OF NURSING HOME OR REST HOME RATES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 93 of the General Laws is hereby amended by adding the following three sections: —

Section 77. No long-term care facility licensed under section 72 of chapter 111 of the General Laws shall seek, as a condition of admittance, any advanced payment or guaranteed length of payment at a private pay rate for those who are presently receiving or are otherwise eligible for public assistance. Such an act or practice shall constitute an unfair or deceptive act or practice under section 2 of chapter 93A of the General Laws.

Section 78. No long-term care facility licensed under section 72, of chapter 111 of the General Laws, shall require supplementation of the publicly assisted rate established by the Rate Setting Commission under section 35 of chapter 6A of the General Laws as a condition of admittance or from individuals acting on their behalf. Such act or practice shall constitute an unfair or deceptive act or practice under section 2 of chapter 93A of the General Laws.

Section 79. In addition to any other relief provided by law, any person who suffers any loss of money or property, real or personal, as a result of the use or employment of an act or preactice prohibited by sections 77 or 78 of this chapter shall be entitled to relief under section 11 of chapter 93A of the General Laws.

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HOUSE . . . . No. 84

Accompanying the tenth recommendation of Executive Office of Elder Affairs (House, No. 74.) Health Care.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Six.

AN ACT RELATIVE TO THE TRAINING AND CERTIFICATION OF NURSES AIDES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 111 of the General Laws is hereby amended by adding after Section 72V the following three sections: —

Section 72W. In this section and sections 72X to 72Y inclusive, the following definitions shall apply:

"Uncertified nurses aides," any unlicensed person who gains employment involving direct nursing care of patients in a long term care facility, who has not successfully completed a certified nurses aide training program and passed a certification exam.

"Long term care facility," a convalescent home, nursing home, rest home, or charitable home for the aged licensed under the provisions of section 71 of this chapter.

"Nurses aide training program," any program which incorporates the minimum criteria for the training and certification of nurses aides developed by the Commissioner, the Secretary of Elder Affairs and the Board of Registration in Nursing, under the provisions of section 72X.

"Certified nurses aide," any person who has been certified pursuant to section 72X.

Section 72X. The Commissioner shall establish jointly with the Secretary of Elder Affairs, and the Board of Registration in Nursing, minimum criteria for the training and certification of uncertified nurses aides. Such criteria shall constitute the mandatory part of any program devised and conduted for the training of uncertified nursing personnel. Said criteria shall be established within one year of the effective date of this act as regulations of the Department of Public Health.

Section 72Y. Any person administering a long term care facility licensed under the provisions of section 71 who hires an uncertified nurses aide or has on staff any uncertified nurses aides with less than three months employment, shall provide for the training of said uncertified nurses aides in a certification training program established pursuant to section 72X within thirty days of the first date of his/her employment, or within thirty days of the effective date of such regulations, whichever occurs first.

Any uncertified nurses aide who has been employed for three consecutive months as of the effective date of such regulations shall be certified upon successful completion of a mandatory certification examination. If any uncertified nurses aide shall fail to pass such certification examination, he/she shall become certified by successfully completing a certification training program and re-examination established pursuant to paragraph one of this section.

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HOUSE . . . . No. 85

Accompanying the eleventh recommendation of Executive Office of Elder Affairs (House, No. 74). Health Care.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Six.

AN ACT TO INSURE THE ELDERLY EQUAL ACCESS TO LONG TERM CARE FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 111 S72 of the General Laws is hereby amended by inserting after section 72V the following three sections: —

Section 72W. Equal Access to Long Term Care Facilities:

Each long term care facility licensed pursuant to section 72 of this chapter and participating in the medical assistance program pursuant to section 18 of chapter 118E shall:

(a) provide a receipt to each applicant for admission to its facility who requests placement on a waiting list stating the date and time of such request, and the level of care sought by the applicant;

(b) shall not refuse to take an application from any person unless the applicant requires a level of care not provided by the facility;

(c) shall not request the source of payment at the time of application or any time prior to the individual's being accepted at the facility;

(d) maintain a dated list of such applications and placements which shall be available at all times to an applicant, his bona fide representative, authorized personnel from the Department of Public Health, Public Welfare and Elder Affairs, including, but not limited to representatives of the Statewide Long Term Care Ombudsman Program, and such other state agencies or other bodies established by state statute whose statutory duties necessitate access to such lists. The inspection of such lists of applications and placements shall be reviewed periodically by the Department of Public Health and shall be included in the annual survey of long term care facilities for certification in the medical assistance program.

Section 72X. The admission by a long term care facility subject to section 72W of this chapter of a privately paying applicant before the admission of an applicant who is eligible for, or receiving medical assistance under chapter one hundred eighteen of the General Laws, shall create a rebuttable presumption of discrimination made unlawful herein. This shall not preclude a long term care facility from making emergency placements based on criteria to be established by the Department of Public Health.

Section 72Y. Violation of sections 72W or 72X shall be punished by a fine of not less than two thousand dollars per occurrence. More than one violation of sections 72W or 72X by a long term care facility during a calendar year shall constitute grounds for the revocation of the certification of participation of such facility in the medical assistance program.

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ahca
American Health Care Association 1200 15th Street, Washington, DC 20005 (202) 833-2050

June 24, 1986

Honorable John Heinz
Chairman
Special Committee on Aging
SD-G33 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Heinz:

This letter is a follow-up to my earlier correspondence in reaction to the Aging Committee's report and hearing, Nursing Home Care: The Unfinished Agenda.

As you know, the Committee's activities have generated significant and nationwide publicity about nursing homes. We continue to receive numerous inquiries. In short, the public and our membership are very concerned about accusations as to the high incidence of substandard care in the nation's nursing homes.

It is our understanding that the critical data on which the staff's report is based is the facility-specific data compiled by the Health Care Financing Administration. We assume the Committee's objective in issuing the report was to raise public awareness about problem facilities as well as to show the need for legislative and regulatory changes for the current system of federal standards and certification. We therefore request that the Committee release the names and addresses of "seriously deficient" and "substandard" nursing homes, according to the classification system used in the report, as well as any additional relevant information about the methodology of the classification.

We believe the Committee has a responsibility to the public and providers to disclose this facility-specific information. Consumers have a right to know so they can be assured they will receive appropriate care.

From the provider's standpoint, we believe that most of the facility deficiencies cited are, in fact, problems which have limited relatonship to the quality of patient care. We think you will find the major problems are with a faulty database and an inspection process that focuses on procedures and paperwork requirements.

Furthermore, we believe that examination of the facility listing will show that most of the deficiencies cited were quickly corrected, and full compliance was achieved within the designated time. Where facility non-compliance is directly related to quality care, we will support immediate and appropriate action to assure full and prompt compliance.

A non-profit organization of proprietary and non-proprietary long term health care facilities dedicated to improving health care of the convalescent and chronically ill of all ages. An equal opportunity employer.

We are persuaded that an affirmative response to our request will allow a more accurate assessment of the current status of nursing home care in the United States. We look forward to your reply.

Sincerely,

Paul Willging
Paul R. Willging, Ph.D.
Executive Vice President

PRW:GC

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

June 26, 1986

Paul R. Willging, Ph.D.
Executive Vice President
American Health Care Association
1200 15th Street, N.W.
Washington, D.C. 20005

Dear Dr. Willging:

Thank you for your letter of May 27, 1986 regarding the Aging Committee's hearing, "Nursing Home Care: The Unfinished Agenda," that was conducted on May 21, 1986.

I am pleased that you support many of our recommendations, including improved intermediate sanction regulations, patient oriented survey systems, a strengthened ombudsman program, and a fair and equitable reimbursement system. I agree wholeheartedly that there is much to be improved in these and other areas of long term care; and I am certain that your Association's valuable input would serve the Congress well in its efforts to address the unfinished agenda in long term care.

Further, I share your disappointment over the Committee's findings regarding reports of substandard care in skilled nursing facilities (SNFs). I would have much preferred that the data had shown few, if any, nursing homes providing substandard care.

Your contention, however, that our findings on "failure to comply" with the "24-hour nursing service standard" relate to "paperwork" compliance is incorrect. To the contrary, nursing home inspection reports contain more than ample evidence to show that these citations do, indeed, involve grossly deficient patient care--not just "paperwork" errors. Please find enclosed a summary of examples.

I also strongly disagree with your characterization of the Committee's analysis and methodology. Let me assure you that our numerical findings were based upon careful and conservative analysis of data from the Health Care Financing Administration's (HCFA) Medicare/Medicaid Automated Certification System (MMACS) provided to the Committee by the General Accounting Office (GAO). I share your concern that the existing survey and inspection process, which provides the basis for these data, does not adequately measure patient outcome and quality of care. Nonetheless, I am sure you will agree that the 25 requirements chosen for Committee analysis are among the most critical to the health and safety of patients, and that they are the best we have available at this time.

A General Accounting Office survey of experts in nursing home care strongly affirms the appropriateness of the 25 requirements chosen by Committee staff for analysis. Among the 26 respondents to the survey were 14 long term care providers and associations, 4 enforcement officials, and 8 organizations representing physicians, nurses and nursing home residents. The respondents awarded an average score of 4.24, on a scale of 5.0, to our choice of requirements "considered most important to patient care, health and safety." Respondents ranked the three "conditions of participation," on which we chose to focus, as first, second and third in importance to patient care.

The Committee staff report identified as substandard 34 percent of the SNFs that failed to comply in 1984 with at least one of the 25 critical patient outcome-oriented conditions and standards chosen from the 541 requirements for federal certification. HCFA's lengthier list of "critical" compliance items would have raised the total to 55 percent. Had the Committee chosen to focus on all 541 requirements, we could have reported that 99 percent of the 8,852 SNFs had not fully complied in 1984. Please find enclosed a listing of the 25 critical requirements utilized in Committee staff analyses.

The term "grossly substandard" was applied to 987 SNFs that were identified as having violated three or more of the 25 "critical minimum standards" in 1984. HCFA's MMACS database revealed that 582 (6.6%) of the SNFs had failed at least three of the 25 critical health and safety standards on three or more inspections out of the most recent four on-site surveys. These facilities were identified as "chronically and grossly substandard."

Findings of the Office of Inspector General (OIG), Department of Health and Human Services, offer further evidence that the Committee staff analyses are, indeed, very conservative. According to the OIG, there are lengthy delays in updating the MMACS database, and thousands of nursing home inspection reports containing violations have yet to be added to the database. Furthermore, a report on an OIG investigation of nursing homes in a western state last November stated:

> "According to State survey officials, no one wants to cite an administrator as deficient because of the pressures that would be brought against the surveyor.***Certain surveyors indicated that if a surveyor insisted on being tough on administrators, the surveyor could be transferred to another area."

The Institute of Medicine (IoM) called attention in its recent report to "the serious, even shocking, inadequacies of enforcement in many states," and further stated that "the problem appears to be national in scope."

I believe it is likely that, if the MMACS database were current and if there were not a reluctance on the part of some surveyors to cite nursing homes for more violations, the figures in the Committee staff report would have been larger.

While you may disagree with the Committee staff report's terminology, we are in total agreement on the central issue of the need to solve the remaining problems in long term care. The Committee welcomes your assistance in this endeavor.

I look forward to working with your Association and others as we go about the task of ensuring quality in long term care for all Americans.

Sincerely,

JOHN HEINZ
Chairman

Enclosure

JH:jfm

SENATE SPECIAL COMMITTEE ON AGING

SELECTED KEY CONDITIONS, STANDARDS AND ELEMENTS FOR COMPLIANCE BY SKILLED NURSING FACILITIES

F15. Condition II -- The Skilled Nursing Facility (SNF) has an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility.

F62. Standard: Patients' rights. -- The governing body of the facility establishes written policies regarding the rights and responsibilities of patients.

F70 Element: Patient is transferred or discharged for legitimate reasons (medical, welfare of other patients) and is given reasonable advance notice.

F71 Element: Patient is encouraged and assisted to exercise his/her rights (voice grievances and recommend changes without interference, discrimination and reprisal).

F73 Element: Patient is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized by a physician (for limited time) or when necessary for protection of the patient and others.

F101 Condition IV. -- Physician Services. Patients are admitted only upon recommendation of, and remain under the care of, a physician.

F105 Standard: Patient Supervision By Physician.

F111 Element: Patient's total program of care (drugs & treatments) is reviewed by a physician every 30 days for the first 90 days, and revised as necessary.

F112 Element: A progress note is written and signed by the physician on each visit, and the physician signs all orders.

F123 Condition V. -- Nursing Services. The SNF provides 24-hour service by licensed nurses (services of an RN at least during the day tour of duty 7 days a week. There are enough nurses to meet the total nursing needs of all patients.

F134 Standard: Twenty-four-hour nursing service.

F135 Element: 24-hour nursing services to meet total nursing needs.

F136 Element: nursing policies ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, cleaned, well-groomed, and protected from accident, injury, and infection.

F173 Standard: Rehabilitative Nursing Care.

F175 Element: an active program of rehabilitative nursing care and is directed toward each patient achieving and maintaining an optimal level of self-care and independence.

F176 Element: Rehabilitative nursing care services are performed daily for those patients who require it, and are recorded routinely.

F177 Standard: Supervision Of Patient Nutrition.

F178 Element: Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist where needed in feeding patients.

F180 Element: Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and physician.

F181 Standard: Administration Of Drugs.

F182 Element: Drugs and biologicals are administered only by physicians, licensed nursing personnel, or by personnel with State-approved training.

F186 Element: administration of a drug is properly recorded by the person administering.

F189 Standard: Conformance with physicians' drug orders.

F190 Element: Drugs are administered according to written orders of the physician.

F191 Element: Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies.

SUMMARY OF EXAMPLES:

NURSING HOME VIOLATIONS TAKEN FROM INSPECTION REPORTS

THAT PROVIDE THE BASIS FOR MMACS, THE FEDERAL DATABASE.

The following excerpts from nursing home inspection reports illustrate that the Medicare/Medicaid Automated Certification System (MMACS) is based on actual violations of patient care, rather than on "paperwork" errors. These excerpts were taken from inspection reports on nursing homes in various locales.

F 136: "The [facility's] policies are designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection; and encouraged, assisted, and trained in self care and group-activities."

Date of Inspection	Inspector's Findings
3/23/84	"Policy to ensure each patient receives proper care to prevent decubitus ulcer and deformities are not implemented based upon the following findings...5 instances where patients with existing skin breakdowns were found lying in urine soaked linen during survey....2 instances where licensed staff failed to carry out physicians' order for treatment of decubitus ulcers."
3/4/83	"Patients are not receiving the necessary care and treatment required to prevent decubiti ulcers. Indicators used are: "1. Statistical Reports. [Nursing Wing #1] (a) 84% of these patients have decubiti; (b) 3% of the patients are receiving special skin care....[Nursing Wing #2] (a) 65% of these patients have decubiti; (b) 2% of the patients are receiving special skin care...." "2. Interview of Patients. Signs are posted when [patients are] turned and positioned, however, the patients interviewed indicated this was not being followed."
4/3/85	"Policies designed to ensure that each patient receives treatments as prescribed were not followed consistently. Reference: 7 patients not receiving treatments as ordered."

"Policies designed to ensure that each patient receives care to prevent decubitus ulcers were not followed consistently in that 13 patients were not given care to prevent the formation and progression of decubiti, contractures, and deformities. Such care did not include the following: [1] changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient (10 instances noted)....[2] Providing care to maintain clean, dry skin free from feces and urine (5 instances noted)."

4/16/82 "The total needs of the patients are not being met. There is no planned schedule, or documentation of turning patients on a regular basis for prevention and promotion of healing of decubitus. One unit had 20 patients out of 23 with decubitus."

5/17/85 "Facility fails to provide for sufficient nursing service to meet the total nursing needs of all patients....one patient with a tracheostomy tube has dressings changed every other day as per nursing staff, and not every four hours or PRN as per doctor's orders...one patient has an order for a restorative aide to ambulate patient 5 times per week with the walker. Walker is not being used. Charge nurse and M.D. not aware [of this]."

10/25/82 "Policies designed to ensure that each patient receives treatment medications as prescribed were not followed as evidenced by...A patient with current order for arm support to immobilize a right arm fracture was noted without an arm support."

"Policies designed to ensure that each patient is kept comfortable were not followed as evidenced by...Bilateral wrist restraint was observed improperly applied on a patient...Call bells were not consistently answered in a timely manner."

"Policy designed to ensure that each patient is kept clean and well-groomed was not followed as evidenced by...5 of 13 patients on Station III were in need of oral care; 4 of the same 13 patients were in need of special care for dry and scaly skin of the lower extremities."

"Policies designed to ensure that each patient receives care to prevent decubitus ulcers [were] not followed as evidenced by...During survey, patients were observed restrained for periods

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	exceeding two hours without being released for position change or toileting."
9/14/83	"The preventive method such as turning and positioning bedridden patients is being done every 4 hours. Staffing...indicated...insufficient staff to meet basic needs and to include timely positioning and turning every two hours."
9/29/81	"Treatments and medications are not being [provided] as prescribed...two patients with egg-crate mattresses ordered for an extended period of time previously were without them when observed."

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510

June 26, 1986

Ms. Kristen Casey
Program Coordinator
Napa County Ombudsman Program
c/o Volunteer Center of Napa County, Inc.
1700 Second Street, Suite 308
Napa, California 94559

Dear Ms. Casey:

We want to take this opportunity to thank you and your colleagues in the Napa County Ombudsman Program for your very able assistance to the Special Committee on Aging.

In particular, we wish to express our appreciation for your help with our recent hearing "Nursing Home Care: the Unfinished Agenda," which focused national attention on this important policy issue. The success of this hearing was due, in large part, to information provided by you and other ombudsmen from throughout the country. Your client, Peggy Dowling, was an exemplary witness who provided crucial testimony in the form of her personal story.

Over the past year, the long-term care ombudsman program has begun to receive the attention it deserves at the national level. As our hearing record indicates, we strongly support strengthening the program. You will be pleased to know that we have just introduced legislation that will improve the ability of ombudsmen to effectively advocate on behalf of their clients, as well as make significant reforms in the requirements and procedures for the certification and survey of nursing homes participating in Medicare and Medicaid. We are enclosing a copy of the legislation and our floor statements introducing it.

Ombudsman programs embody the spirit of the Older Americans Act in striving to ensure that the elderly clients they serve are treated with respect and dignity. You provide a fine example of what this essential program is about. Again, we thank you for your help and look forward to continuing to work together in the future.

Sincerely,

John Heinz
JOHN HEINZ
Chairman

John Glenn
JOHN GLENN
Ranking Member

Enclosures

cc: Ms. Esther Rains, California State Ombudsman

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June 26, 1986

Mr. James J. Hoffman
Evaluator
U.S. General Accounting Office
Tower 2 Bldg., Rm. 717
4th and State Streets
Kansas City, Kan. 66101

Dear Mr. Hoffman:

As Chairman of the Special Committee on Aging, I am writing to thank you for your invaluable assistance in preparation for the Committee's May 21, 1986 hearing on "Nursing Home Care: The Unfinished Agenda."

Your very excellent work in extrapolating data for us from the Medicare/Medicaid Automated Certification System (MMACS) enabled the Committee to provide evidence of the fact that there is, indeed, much left to be accomplished toward improving the survey and certification system. Further, your data unquestionably underscored the critical need for strengthening nursing home regulation and patients rights.

On behalf of the Committee, I commend you for the exceptional work you performed in the interest of all Medicare and Medicaid beneficiaries. Committee staff have informed me of the many long hours you worked under pressure to accommodate our needs. I am especially appreciative of your extra effort.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH:jfm

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June 26, 1986

Mr. Donald Ficklin
Evaluator
U.S. General Accounting Office
Tower 2 Bldg., Rm. 717
4th and State Streets
Kansas City, Kan. 66101

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June 26, 1986

Ms. Denise Wempe
Evaluator
U.S. General Accounting Office
Tower 2 Bldg., Rm. 717
4th and State Streets
Kansas City, Kan. 66101

Dear Ms. Wempe:

As Chairman of the Special Committee on Aging, I am writing to thank you for your invaluable assistance in preparation for the Committee's May 21, 1986 hearing on "Nursing Home Care: The Unfinished Agenda."

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John Heinz

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JH:jfm

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June 26, 1986

Ms. Kathryn G. Allen
Assignment Manager
Human Resources Division
U.S. General Accounting Office
Room 1126
330 C Street, S.W.
Washington, D.C. 20201

Dear Ms. Allen:

As Chairman of the Special Committee on Aging, I am writing to thank you for your invaluable assistance in preparation for the Committee's May 21, 1986 hearing on "Nursing Home Care: The Unfinished Agenda."

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June 26, 1986

Mr. James R. Linz
Group Director
Human Resources Division
U.S. General Accounting Office
Room 1126
330 C Street, S.W.
Washington, D.C. 20201

Dear Mr. Linz:

As Chairman of the Special Committee on Aging, I am writing to thank you for your invaluable assistance in preparation for the Committee's May 21, 1986 hearing on "Nursing Home Care: The Unfinished Agenda."

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Sincerely,

John Heinz

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Chairman

JH:jfm

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WASHINGTON, DC 20510

June 27, 1986

Mr. Robert H. Finch
350 West Colorado Boulevard
Suite 310
Pasadena, California 91105

Dear Bob:

Thank you for your recent letter regarding the Senate Special Committee on Aging Hearing held May 21 on nursing home abuse. I would have liked to respond more promptly to your letter but the tax reform debate has curtailed my time for personal correspondence.

As the former Secretary of Health, Education and Welfare, you are aware of the physical, emotional and financial abuse suffered by many nursing home patients. Although there has been some improvement in patient care, the Committee's two-year ongoing investigation into nursing home abuse and substandard quality of care found that such abuses continue to be widespread. Having seen the Committee report, I am satisfied that the Aging Committee staff accurately depicted the extent of abuses occurring in nursing homes and the Administration's inattention and inability to adequately monitor these problems.

The Aging Committee staff has assured me that they are willing to meet with representatives from Beverly Enterprises to review and discuss the data used in their report. I believe that such a meeting should include discussions about how the public and private sectors can work together to improve the quality of care to our older citizens. Improved cooperation between the private sector and the federal government could enable us to quickly and effectively reduce nursing home abuse. I believe that Beverly Enterprises can provide dynamic leadership for both the federal government and the nursing home industry in caring for our elderly.

Mr. Robert H. Finch
June 27, 1986
Page Two

Bob, I greatly appreciate your interest on behalf of Beverly Enterprises to educate me about their corporate plans to develop and implement caring and innovative programs for the elderly. I hope Beverly's competitors will mirror their efforts to improve the overall delivery of our Nation's long-term care services.

Again, thank you for your letter.

With kindest regards,

Pete

1125 Pine Grove Drive
Alpharetta, GA 30201
July 31, 1986

U.S. Senate Special Committee on Aging
Mr. David Schulke, Investigator
G-33 Dirksen Office Bldg.
Washington, DC 20510

Dear David:

I received the copy of S2604 and I am so excited about it I can hardly contain myself. You have certainly done your homework. Each time I wondered whether something was covered, I found it soon followed. I can't think of anything you missed.

I was delighted to find provisions for mandatory certified nursing assistant training programs, investigation of employees' backgrounds, non-discrimination against Medicaid patients, fines to back up such instances as chronic non-compliance and patient/employee complaint retaliations. The provision permitting patients to go to court for enforcement is terribly important in states where patients lack clout due to local politics. And so often the quality of nursing home care is in the hands of a few people with a great deal of political influence. Georgia is an excellent example of that.

Your recognition of those with Durable Power of Attorney and Representative Payee status as legitimate patient representatives is so important. It is one of the points I regretted not making in my statement. I was both Representative Payee and I held Durable Power of Attorney for my mother, but no health care official ever acknowledged either status. Declaring a loved one incompetent to obtain Guardianship is such a painful process that most families will avoid it at all costs. As a result, the fact that a person is too ill or confused to participate in his own health care is used by health care providers as an opportunity to expediently make all health care decisions. This leaves health care providers without any background patient information; it leads to poorer quality health care decisions; and it keeps loved ones at arms length, always two steps behind what is happening, racing to keep up. But I'm sure you already know all this.

All in all, David, you folks did a brilliant job. I wish I were more knowledgeable when it comes to such matters as legislation. Will this resemble its present state when it leaves the finance committee? I can't bear to think of it watered down to nothing.

I wish I knew of some sure-fire moves I could make to help, but I guess you'll have to settle for the only thing I know how to do--write. I'll keep sending out my letters and the booklets you gave me and just keep stirring it up.

Good luck.

Best regards,

Dorothy Doyle

Dorothy A. Doyle

OMBUDSMAN PROGRAM
VOLUNTEER CENTER OF NAPA COUNTY, Inc.
1700 2ND ST., SUITE 308
NAPA, CALIFORNIA 94559 (707) 252-6222

August 2, 1986

TO : David Schulke, Investigator
Senate Special Committee on Aging

FROM: Kristin Casey, Coordinator
Napa County Ombudsman Program

RE : Comments to be added to recent study of nursing home care

The July 18 CAHF "Long Term Care News" states: "Heinz Reform Legislation Proceeding On 'Fast Track'---AHCA recently expressed grave concern over the fact that Senator John Heinz (R-Pa.) is attempting to place proposed nursing home reform legislation into the Budget Reconciliation Act..As a result, the legislation would not be required to go through the normal legislative hearing process. AHCA has met with Congressional leaders expressing its concern over the legislation being included in the Reconciliation Act."

I just read "Nursing Home Care: The Unfinished Agenda", and I can't applaud the efforts of the Senate Subcommittee on Aging enough. As Coordinator of the Napa County Ombudsman Program for the past five years, I have seen nearly all of the problems brought out in your hearings and exposed by your report. It is my fervent hope that enough Senators and Congressmen can resist the inevitable pressure from the nursing home industry, and rally behind Senator Heinz's efforts to continue to bring the long-term care system, upon which many of our elders depend, into true compliance with decent standards of care. It is time to move beyond "substantial" paper compliance with minimum standards, and begin to embrace a nationally consistent enforcement of the law. The interest currently being demonstrated by our national leaders regarding these issues is most heartening to advocates for nursing home residents.

Per our recent conversation, I would like to add a few comments for the record, based on my experience with many clients in nursing homes during my five years with the program.

The Napa County Ombudsman Program dealt with 2,802 complaints during 1985-86, up from 2,083 in 1984-85. This signifies not simply that problems continue to exist in the nursing home setting, but also that an ongoing and expanded regular presence by Ombudsmen in these facilities allows us to see and hear of the problems to a greater degree than the Licensing agency, which arrives once a year (about the time a facility's license is up for renewal) or in response to complaints.

From an Ombudsman's point of view, it is essential to have the backing of Licensing & Certification as a strong enforcement system. We regularly refer serious or chronic deficiencies to our regional Licensing & Certification office, and we're experiencing an increasingly positive reception to our referred complaints, as the State Department of Health Services responds to public demand to become enforcement-oriented rather than consultation-oriented.

At this point in time, the flow of information between our program and Licensing is one way, usually initiated by us. I believe we could be more fully utilized as a resource by Licensing, for the benefit of our shared clients, if there was a two-way sharing of information about problems in facilities. Not only could we be assisting with feedback and follow-up regarding Licensing's concerns in specific facilities, but Licensing evaluators could also avail themselves of our knowledge about day-to-day conditions in facilities prior to conducting annual surveys and inspections. We see facilities before, after, and between efforts to prepare for their annual survey and I believe this perspective could be useful to Licensing.

I think much more effort needs to go into solving the problem of repeat deficiencies. I don't believe that repeat deficiencies are being caught or cited to the extent that they're occurring.

Our program's experience and statistics support your committee's finding that inadequate nursing care continues to be a problem in the nursing home industry, and that violations of residents' rights persist. Of the total of 2,802 complaints worked on this past year 1,320 related to quality of care, staffing, and abuse; 521 complaints related to residents' rights. Quality of care and abuse problems are often directly related to inadequate staffing. California's minimum requirement of 3.0 hours of care per 24 hour day is a cruel joke when one considers that nursing homes are allowed to double nurses' hours on paper in order to meet the requirement, and that more patients are being admitted with heavier care needs as they're being discharged sooner from hospitals. I believe we need to mandate an aide-to-patient ratio for each shift instead of allowing facilities to average the three shifts and double the nurses' hours in order to reach the meaningless 3.0 figure. I also believe that nurse assistants, who perform around 70% of the direct patient care given in nursing homes, must be targeted for increased wages, training and recognition.

My final comment is to echo your recommendation that HCFA expand the hospital swing-bed program. In the city of Napa, the acute care hospital has recently designated a wing for skilled nursing care, and one result has been an elimination of waiting lists for nursing nome beds. This, from our point of view, is a positive step in the direction of a more competitive system in which the consumer wields some power for a change. This situation forces improvement in the nursing homes and in what they offer, and discourages discrimination against Medicaid patients.

Thank you for hearing my concerns and for the valuable work you're doing.

OMBUDSMAN PROGRAM

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MONTHLY STATISTICS

Month/Year

OMBUDSMAN

FY 84-85
Name of Facility

2,083
Total # New Complaints

CATEGORY	NUMBER	CATEGORY	NUMBER
RESIDENTS RIGHTS:		QUALITY OF CARE:	
Verbal Abuse	16	Medication	8
Improper Use of Restraint	17	Nursing Care	453
Dehumanizing	53	Rehabilitation	13
Call Bell Not Available	50	Personal Hygiene	112
Retaliation	18	Positioning	115
Roommate Problem	17	Call Bell Response	29
Laundry Problem	15	Hydration	53
Privacy	45	Lack of Assistance w/ Eating	25
Staff Language Barrier	3	Not Taken to Bathroom Regularly	31
Security of Possessions	37	Excessively Dry Skin	9
Religious/Civil Liberties	102	Rough Aide	16
Transfer/Discharge	3	No Patient Identification	18
Physical Abuse	3	Medical Care	45
Social Services	13	Activity Program	93
Pharmacy	7	Other: 1,020	
Other: 399			
ADMINISTRATION:		FINANCIAL/LEGAL:	
Policies	42	Charged for Services Not Provided	6
Attitudes of Staff	52	Refund Denied	1
Discrimination	-	Questionable Charges	19
Ombudsman Poster	19	Personal Needs Allowance	18
Interference w/ Ombudsman	5	Accounting Denied	2
Insufficient Linen	17	Billing Problem	10
Threadbare Linen	15	Medi-Care	2
Guarantor Illegally Required	6	Medi-Cal	8
Deposit Illegally Required	1	Conservatorship Problem	5
Staffing	65	Legal Problem	11
Placement Problem	14	Other: 82	
Other: 236			
PHYSICAL PLANT:		DIETARY:	
Facility Cleanliness	82	Cold	12
Facility Temperature	32	Quality of Food	50
Building Condition	35	Insufficient	13
Equipment Cleanliness	15	Snacks	8
Equipment Repair	22	Special Diet	10
Safety Factors	28	Time Lapse Between Meals	7
Urine Odor	32	Other: 100	
Other: 246			

OMBUDSMAN PROGRAM
VOLUNTEER CENTER OF NAPA COUNTY, Inc.

1801 OAK STREET
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March 14, 1984

Testimony before the Senate Health & Human Services Committee
concerning Patients' Rights and retaliation
in skilled nursing facilities.

My name is Kristin Casey. I have worked as the Director of the Ombudsman Program in Napa County for three years. Previous to this, I was employed as a Certified Nurse Assistant and later as an Activity Director in a skilled nursing facility, following 10 years in the field of teaching.

I am here to strongly urge you to vote in favor of the bills before you which most strongly embody the recommendations of the Little Hoover Commission.

I would like to specifically address two issues today, namely, making the violation of Patients' Rights or welfare a class "B" violation (S.B.1347), and raising the maximum fine for retaliation against complainants (S.B.1341).

PATIENTS' RIGHTS

It is a sad commentary on our society that a "Patients' Bill of Rights" had to be enacted into law in the first place. To think that we could not depend on this country's basic Bill of Rights and Constitutionally-guaranteed civil rights to adequately protect the elders of our country who have the misfortune of not only growing old, but also becoming ill and in need of nursing home care, is a disgrace. However, these patients' rights were added to the regulations for nursing homes, in 1974, as a specific reaction to abuses which had come to light during the previous decade.

I believe, after observing nursing homes and working with nursing home patients for the last 6 years, that Patients' Rights must be made more enforceable.

In order to do this, the violation of these rights needs to be raised from a meaningless, throw-away "deficiency" on a facility's record, to a "B" violation, which carries with it a fine and consequently would be taken more seriously. To elevate the sanction for violating patients' rights also elevates the importance of these rights themselves.

If a fine accompanied the substantiated violation of a patient's rights, this would act as a deterrent, and would probably also create an impetus in the nursing home industry to enhance its staff training relating to awareness of, and upholding of, patients' rights. This measure would not adversely affect the many facilities who take patients' rights seriously and both train and carefully supervise staff in relation to this very basic issue. For these facilities, nothing would change by adopting this measure; but for patients of facilities in which adherence to patients' rights is not stressed, adopting this measure could greatly improve the quality of their day-to-day life.

During the F.Y. 1982-83, the Napa County Ombudsman Program dealt with 574 complaints, with 123 of those (22%) relating to problems with Patients' Rights. Attached you will find a list of examples of these problems and complaints.

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RETALIATION

In my dealings with nursing home patients and their families during the past 6 years, it has become clear that retaliation, or the threat of it, does exist when complaints are made on behalf of patients in LTC facilities. This does not mean that retaliation for raising a complaint occurs in all cases or in all facilities. However, in the instances where this does occur, it has a devastating effect on patients who, in the final analysis, depend on the good will of their facility and its staff on a 24-hour basis.

The bottom-line fear for patients on whose behalf complaints are raised, is eviction from the facility. The blatant act of simply evicting a complaining patient is not a usual occurrence; the fear of eviction seems to stem more from commonly-heard statements such as "If you don't like it here, move to another facility", or "If you don't like the way we're taking care of your mother, you can take her out."

In one case in which I was involved, the administrator was pressuring a family to take their aunt out of his facility, ostensibly because she was "too heavy" (161 #), and he didn't want his aides hurting their backs. Another reason emerged, however, during our meeting with him, when he said, "We got one complaint in 4 years from Licensing, and it had to come from this family. This is a tension problem. Why not relieve the tension?" (i.e., have family and patient leave).

Subtle retaliation toward complaining patients includes:

- Witholding a meal until after all others are served, or until the patient is deemed "worthy" of receiving it.
- Labelling the patient "paranoid" or "confused" or "a complainer".
- Instituting or increasing the use of tranquilizers (Haldol, Thorazine, Mellaril), to help the patient "calm down" or "cope" or to "lessen the patient's agitation".
- Leaving the patient's bedroom door closed, or curtain pulled, thus isolating him/her.

- Putting call bell out of reach, or not answering the bell, or answering it by simply turning it off and leaving.
- Verbally reprimanding the patient for using call bell.
- Moving complaining patients to the "back wing".
- Conveying a negative and non-caring attitude toward the patient.
- Delaying the administering of medication.
- Leaving water out of reach; not offering or helping the patient to water.
- Refraining from helping the patient get to the bathroom in order to prevent incontinence. Leaving patient in his/her urine or feces.
- Cutting off communication with the patient.
- Assigning the patient to an inappropriate roommate.
- Being increasingly impatient and negative toward the patient and/or family.
- Giving inadequate grooming care, resulting in unclean and disheveled-looking patient.

I ask that you simply take a moment to put yourself in the place of the nursing home patients for whom the above-mentioned actions are a reality or an anticipated fear. Thank you for this timely attention to nursing home reform.

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EXAMPLES OF VIOLATIONS OF PATIENTS' RIGHTS

- Patients and families, on admission, not always fully informed of Patients' Rights.
- Patients and families not clearly informed of their right to use the pharmacy of their own choice; often are influenced to use a pharmacy which is the preference of the corporation. These large pharmacies are usually located in another county.
- Reprisal and subtle retaliation, following the voicing of complaints, is very common.
- Mail is sometimes opened by facility before delivery to patient.
- Patients transported to shower in shower chair--often improperly covered, leaving patient's bare back and buttocks exposed.
- Patients receiving care in bed with privacy curtain left open, exposing them to view from hall.
- I have also seen a patient being given catheter care in her open doorway.
- Patients left lying in bed, bare and exposed from neck to waist.
- Call bells placed out of reach (sometimes on floor or on chair next to bed), or not responded to.
- Patients not taken to bathroom regularly in order to avoid incontinence. Patients are humiliated when they have no choice but to urinate or defecate on themselves.
- Patients left in their own urine or feces when served breakfast in bed.
- Patients left wet in wheelchairs after having been incontinent.
- Patients often changed but not cleaned following urinary incontinence, resulting in odor and possible skin irritation.

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- Patients spoken to rudely, sometimes yelled at; not treated with dignity or respect.

- In one instance, a bedridden male patient was threatened with castration if he continued to be incontinent in bed.

- In another instance, a female patient was subjected to sexual manipulation by an aide (who claimed not to know better), but neither a deficiency nor a citation was issued because the facility notified Licensing about the incident and let the employee go.

- On one occasion, a patient witnessed an incident in which her husband (also a patient) was shoved down onto his bed by a staff member, resulting in a dislocated shoulder. Again, the facility let the employee go, so did not have to bear any responsibility for the incident.

- Patients too often appear unkempt, not showing evidence of good personal hygiene and basic care.

- Personal possessions, as well as personal clothing, too often turn up missing. These items are all that a patient has left call his/her own.

- Low staffing sometimes results in inadequate help given to patients who cannot feed themselves.

- On several occasions, patients have been put in "Attends" (diapers) against their wishes because it is more convenient for staff.

- In some instances, patients have been restricted from wearing their own clothes and kept in hospital gowns because they had not abided by a facility rule.

- I have witnessed one instance when a patient who did not want a shower that day was pulled from his bed and forcefully taken to the shower.

- I have witnessed another instance where a patient refused her medication, and it was forced down her throat.

- I witnessed an instance also, where a patient who did not like showers and resisted taking them was sprayed in the face with the shower hose.

- Sometimes when I visit with patients, staff members of a facility have walked by and announced loudly that a given patient is "very confused"; in many of these instances, the patient in question has understood the comment.

- On one routine visit to a facility, I escorted a wandering patient back to the facility, at which point he was walked to his room by 2 staff people who were heard to say "Maybe he should be permanently restrained." When I later went to this patient's room, I found him in an immovable chair facing the corner of his room, and he had been restrained to this chair by five sheets. A sheet bound each wrist to the chair arms, a sheet bound each ankle to the chair legs, and an additional sheet tied the patient in at the waist. The knots were complicated, and tight enough on the right wrist to noticeably impair circulation.

OMBUDSMAN PROGRAM
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TESTIMONY OF
KRISTIN CASEY
NAPA COUNTY OMBUDSMAN COORDINATOR

for the
COMMISSION ON CALIFORNIA
STATE GOVERNMENT ORGANIZATION
AND ECONOMY

January 28, 1986

My name is Kristin Casey. I have served as the Program Coordinator of the Napa County Ombudsman Program for nearly 5 years. I want to thank the members of the Little Hoover Commission for your continuing interest in, and dedication to, seeing that the quality of care provided to California's elderly nursing home residents meets certain standards.

I believe that without your persistent oversight and without the impetus you have provided for legislation aimed at strengthening enforcement of nursing home regulations, conditions in our nursing homes would be more problematic than they presently are. I also believe that without the scrutiny which you have focused on the nursing home industry, and on the responsibilities of Licensing & Certification to apply meaningful sanctions when the industry is out of compliance, public awareness of the problems would not be as great.

Today we're looking at how well the laws embodied in the Nursing Home Patients' Protection Act of 1984 have been implemented.

One of the positive changes for me has been the increased willingness of the Licensing branch in my area to respond to complaints from our office. An evaluator recently assigned to my territory seems to find time to call the Ombudsman office with follow-up information, and appears to appreciate input from the Ombudsman Program about conditions in the facilities which we monitor on a weekly basis. I have to add that this new sense of cooperation is not always in evidence for other Ombudsman Coordinators with whom I've recently spoken, so the difference may rest as much with the personal philosophy of the individual evaluators or regional offices as with changes in the enforcement system. It wasn't until this past October that evaluators' name badges were recalled and the initials after their names changed from HFC (Health Facility Consultant) to HFE (Health Facility Evaluator), so it may take time for an enforcement ethic to really take hold.

I believe there has been a slight increase in the number of citations issued in my county. I'm pleased that a patient's right to be treated with dignity, including the provision of adequate basic care, has been among the increasingly cited violations. I believe that if the nursing home industry has to begin reaching into its pocket and paying for lapses in patient care, there will be improvement in the care given, because it will be motivated to find ways to put that money into attracting, training and retaining staff rather than lose it in fine payments. Of course, much depends on the likelihood of fines being collected.

Thanks to you, there have been improvements in the nursing home system. There do, of course, remain problems, some of which I address below.

ACCEPTANCE OF STATEMENTS OF WITNESSES

The Nursing Home Patients' Protection Act decreed that Licensing & Certification "may issue a citation based upon, but not limited to, any of the following:

1. observed conditions
2. facility records
3. statements of witnesses

I have received the frustrated report from several Ombudsman Coordinators that the procedure of relying on facility records and on interviews with facility personnel continues to dominate

Licensing's investigative efforts. Additional sources which Ombudsmen feel should be considered are family members, other involved agencies, patients themselves, and Ombudsmen. If both the facility spokesperson and a family member or patient are consulted during a complaint investigation, it remains likely that more credence will be given to the facility spokesperson when it comes down to his/her word against the patient's or family member's word.

Closely related to this problem is the fact that there remains a tendency to not accept an eyewitness statement if the evaluator goes into the facility to investigate and cannot personally witness a re-creation of the complained-about event.

In a case which I recently referred to Licensing, a patient's daughter wrote to me: "Grandma was very tired because we had celebrated her 90th birthday that day, so we asked the nurse if she could lie down a few minutes before supper. The nurse aide got another aide to help her lie Grandma on the bed. In the process, while my sister and I looked on, they abruptly dropped her onto the bed when they had her within 5 or more inches above the bed. She landed hard and bounced back up and then landed with a groan and a very frightened look on her face. One aide said, 'Oh, did you think we were going to drop you? You must have felt your heart beating fast, didn't you?' _I_ (the daughter) said to them that they had better be careful because she had both a fractured shoulder and hip. They never said another word, but walked out quickly."

I mailed the family member's letter to Licensing and received this reply in their report: "Complaint of Rough handling of patients with fractures.--During nursing rounds no pts with fractures noted and no "Rough" handling of patients noted--Unsubstantiated."

INTERVIEWING PATIENTS IN THE PRESENCE OF STAFF

One Ombudsman Coordinator has mentioned a concern to me about inappropriate interviewing techniques used by some Licensing evaluators. In one recent instance, an evaluator interviewed a resident with the facility's Director of Nurses present. The evaluator was investigating a complaint about quality of care in this facility. This came to the attention of the Ombudsman Program when that resident later asked an Ombudsman if that was appropriate, and confided that she had been made to feel very uncomfortable.

CITATIONS CONTESTED IN COURT

At the present time, the Ombudsman Program is notified of Citation Review Conferences, but when facilities either go further and take that decision to court, or bypass the CRC and go directly to court, there seems to be no mechanism for following the progress of cases. I think I speak for all Ombudsman Programs when I say that we are vitally interested not only in the outcome of Citation Review Conferences, but of court proceedings, as well, when the faciity is one which we monitor.

MISCELLANEOUS ISSUES

Facilities are supposed to prominently post "written notice of the right to request an inspection, the procedure for doing so, including the right to remain anonymous, and the prohibition against retaliation." I don't see these in the facilities which I visit; is Licensing to inform facilities of this new requirement and then monitor its implementation?

There remains tremendous confusion in the industry about "patient-oriented councils", and the formation of these is sporadic.

Resident Councils exist in most facilities, but they often provide only a token response to patients' concerns. They invariably have staff present, which can be an inhibiting factor. These councils should belong entirely to the patients. It works in the patients' favor when the Ombudsman assigned to the facility attends these sessions on a regular basis.

In spite of increased reimbursement aimed at paying staff better and increasing staffing, I am hearing from every area that short staffing continues to present a chronic problem in nursing facilities. A related problem is that complaints by staff, family members, and Ombudsmen about short staffing can be "unsubstantiated" by Licensing, depending on what they look at during their investigation. Facilities have been known to leave their written "schedule" full even when it is known that an aide or a nurse won't be in. I've had staff tell me that people were left on the schedule during their vacation. I've been told that aides may fill in gaps by working only a few hours of a shift, but on paper it looks like they're there for the whole shift. It is also important to determine which staff are working in which positions, and to be certain that they're qualified for the position. For instance, students from the local community college should not be used to fulfill the staffing ratio on paper. I had one long-time employee of a facility tell me that she's known facilities to even issue bogus checks, which are never claimed, to give the impression that adequate staff was on duty.

RECOMMENDATIONS

1. Institute the use of formal declarations or depositions for witnesses' statements. These declarations should be acceptable to Licensing as evidence, whether obtained by Ombudsmen or by Licensing evaluators.

2. Require privacy for interviews between evaluators and patients, to protect patients from possible retaliation.

3. Require notification of Ombudsman Programs when court dates are set for contesting citations within their area of jurisdiction.

4. Enforce posting of written notice about requesting inspections.

5. Clarify the purpose of the patient-oriented councils to the industry.

6. More analysis is needed for the crisis in staffing. Special attention is needed for investigation of staffing complaints. The 3.0 requirement over a 24-hour period does not adequately address the issue of what staffing should be. Every Ombudsman and every aide I've ever spoken to about staffing has said that a specific ratio of aide to patients is needed.

CATHOLIC CHARITIES
DIOCESE OF STOCKTON

Mother Lode Ombudsman Program
6 So. Washington St., Room 8
Sonora, CA. 95370

ADDRESS REPLIES TO

Stanislaus Ombudsman Program
914 13th Street
Modesto, CA. 95354

TESTIMONY given to the Little Hoover Commission
January 28, 1986

My name is Maureen Muratore and I am the Director of the Long-Term Care Ombudsman Program covering the counties of Stanislaus, Alpine, Amador, Calaveras, Tuolumne and Mariposa. I am here as a representative of the California Long-Term Care Ombudsman Association to address the implementation of the Nursing Home Patients Protection Act. My input comes both from my own experience, as well as that of my colleagues in the Central Valley of the state.

The Nursing Home Patients Protection Act has had a positive effect by focusing attention on the problems in nursing homes and by requiring Department of Health Services, Licensing and Certification (LCD), staff to emphasize their role of enforcement. In Stanislaus County, there is a skilled nursing facility that has received three class A citations at $30,000.00 each and four class B ciations at $1,000.00 each, since the Protection Act was signed into law. We knew for some time that there were serious problems in this facility, but our concerns were never acted upon by LCD evaluators. Because of the legislation's stress on increased enforcement, I believe this facility was finally given the attention it deserved.

As a consequence of the citations, the heavy penalties and the ensuing publicity, this facility and its corporate officials have made great strides toward improvement in patient care. In late November, a EEE (Enhanced Enforcement Effort) survey was conducted in the facility. No major deficiencies were detected - they "passed with flying colors." I strongly believe this facility has turned around and is providing better patient care because of the Nursing Home Patients Protection Act.

Although there has been a positive impact in the area of problem facilities, by and large, I have not seen a marked difference in the quality of patient care in the majority of nursing homes we cover. Most of these facilities have been and continue to provide decent care for their patients. However, the majority of complaints we receive in those facilities are related to quality of care issues. These complaints are either directly or indirectly related to the inadequate number of CNA's (Certified Nursing Assistants) working in the facility. The level of 3.0 nursing hours per patient per day is simply not enough, especially with the Medicare DRG (Diagnostic Related Groups) system which is releasing heavier care patients from acute care hospitals to nursing homes.

Affiliated with National Conference of Catholic Charities and California Conference of Catholic Charities

The Nursing Home Patients Protection Act did recognize the problem that CNA's, who provide the hands - on patient care, were not paid enough money for the job they did. A well publicized wage increase for non-administrative personnel excited many CNA's, who were later disappointed to discover the increase would only be between 15¢ to 25¢ per hour. I feel strongly that the way to affect better patient care is to spend more money on CNA's - both for their wages and for their training. A former CNA recently told me that she had very much enjoyed her work in a nursing home, as she liked older people and wanted to see them well cared for. She had had to quit her job, however, because she could not make a living wage. I am also concerned about the training that CNA's recieve and have been in nursing homes where novice aides have been out on the floor caring for patients after only three hours of orientation. The San Joaquin Ombudsman told me she had recently been told by a nursing home aide that her facility told staff to sign off on training they had never received. More attention has to be focused on the staff giving the hands - on care to nursing home patients.

Another area of importance impacted by the Protection Act is that of information sharing and publicity. Ombudsman Programs are finally receiving copies of citation reports from the Department of Health Services. These are being shared with consumers, their families and interested members of the community. In Stanislaus County, a member of the press routinely drops by our office to inspect any citation reports we have received. This often results in an article which appears in the local newspaper. I feel that the public, and particularly consumers and their families, have a right to know about these citations and their circumstances.

The extent of cooperation Ombudsman Programs are receiving from Department of Health Services, LCD evaluators and other officials seems to depend on personalities and which district office covers a given area. My colleagues in Kings/Tulare and Kern Counties have seen a marked improvement in the way their evaluators are doing their jobs. They are receiving more cooperation from LCD officials than they have in the past. On the other hand, the Kern County Ombudsman stated that evaluators in that area continue to operate more in the role of a consultant than an enforcer.

All other Ombudsman Programs in the central area of the state, including my own, have had on-going problems with LCD evaluators and officials. In Merced county, a complaint was turned in by the Ombudsman to an LCD official. Weeks later upon hearing nothing from the LCD office, the Ombudsman called them only to find that the person he originally spoke to was on vacation. A search of his desk by LCD staff found the complaint buried under other work. The complaint had never been assigned to an evaluator for the purposes of investigation. The person responsible for burying the complaint is alleged to be a personal friend of the administrator whose facility was involved in the complaint.

This example touches on a problem that is widespread throughout the Central Valley. Although the law specifically states that Department of Health Services must, at the conclusion of its investigation, report its findings to the complainant, this is not in effect being done. On only one occassion, have I received feedback from LCD staff on a complaint I have reported to them. My colleagues, except in Kings/Tulare counties, have also found this to be true.

In addition, other non-Ombudsman complainants have told me of similar experiences. A woman recently came into my office to tell me about her encounter with the Department of Health Services. Her husband had been in a nursing home, where a necrotic ulcer had formed on his leg. His leg was not attended to properly, it eventually developed gangrene and had to be amputated. A series of events happened to him in the acute care hospital (he was not given respiratory treatments he needed and was given someone else's I.V. feeding), which contributed to his death last February. This woman referred her complaints to LCD in the spring of 1985 and received no communication from them until December 27, 1985 (this was after she sent several letters to LCD asking for their response). She has until February 6, 1986 to file a malpractice suit, but has been waiting to receive the results of the LCD investigation before proceeding. Since the initial LCD investigation was made in March of 1985, there is no reason why she should not have been apprised of their findings sooner.

In San Joaquin County, the Ombudsman referred six serious complaints to LCD regarding a wrongful death that had occured in a nursing home. An elderly female patient, who was semi-ambulatory but still needed assistance, was left unattended on the commode. She fell and broke her hip. She had surgery on the hip but died the next day - March 5, 1985. The Ombudsman later learned of the incident and began an investigation. The Coroner's report stated that because of the accident in the nursing home, the surgery contributed to her death. On May 29th, the Ombudsman reported this incident as a complaint to LCD. On September 18, 1985 an evaluator (RN) conducted an investigation in the facility and no deficiencies were cited. The Ombudsman requested a hearing on this decision. At the hearing the district administrator defended the evaluator's position. Furthermore, he made the statement that Ombudsmen have no more authority to review and investigate complaints in nursing homes than members of the general public. He asked the Ombudsman Coordinator where she got her (investigative) training and stated that they (LCD staff) are not trained to be investigators. The Ombudsman has since obtained a statement from the aide in question saying he left the patient unattended on the commode. He also told the Ombudsman that he had been desciplined by the facility for doing so and gave her a copy of the written disciplinary action. This document had been in his personnel file along with his statement. The LCD evaluator had not found these during her "investigation".

This example shows not only that LCD staff from this district office are not cooperating with Ombudsmen, but also that serious attitudinal problems exist there. Activity directors from three different nursing homes in San Joaquin County recently told the Ombudsman that an LCD evaluator told them not to contact the Ombudsman if a problem arises; rather, they should call LCD and refer it directly to them. This kind of statement is confusing to the facility staff, patients and family members. One of the goals of the Ombudsman Program is to resolve problems or concerns at the local level, preferably before they become a major issue.

In summary, I feel that there has been progress toward improving care for patients in nursing homes. We cannot stop here, though, and feel that the job has been done. Nursing home residents need to have our continued interest in their welfare and our advocacy on their behalf.

OMBUDSMAN PROGRAM
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April 8, 1986

Testimony on behalf of AB 3943 (Agnos) re: prohibition of Guarantor requirement in SNF and ICF admissions agreements.

Submitted to: Assembly Health Committee

Submitted by: Kristin Casey, Napa County Ombudsman Coordinator

I am here today to urge members of this committee to vote affirmatively on AB 3943.

I have been the Coordinator of the Napa County Ombudsman Program for nearly 5 years. During this time I have received and worked on numerous complaints concerning the issue of long-term care health facilities requiring prospective patients to have a "responsible party" or "guarantor" sign their admission agreement as a condition of admission.

In some of these cases, the patient in question was a competent adult, capable of signing himself or herself into a facility as his/her own responsible party, and for paying his or her own bills. It is my contention that the right to be responsible for oneself should be given competent adults, even if they happen to be old and in need of nursing home care. Nursing home patients do, in fact, have a stated right to manage their own financial affairs.

In many of the cases with which I've dealt, the patient's care was eligible for coverage by Medi-Cal. Under the Social Security Act, 42 USC 1396 h (d), I believe that Medi-Cal payment to a facility, plus the patient's share of cost, is supposed to be considered "payment in full" to nursing homes. To ask a relative, friend, or social worker to assume personal liability for any basic charges could be construed as a request for "other consideration", which is prohibited.

I have known family members, often elderly themselves and on fixed incomes, who have felt they had no choice but to sign as a patient's personal Guarantor of payment. They so signed the admission agreement under duress, having been told that otherwise the patient would not be accepted into the facility. These individuals then found themselves being held personally liable for such things as non-covered medications (in the amount of as much as $200 per month), miscellaneous "supplies" and other goods and services. Now, thanks to the Johnson v. Rank decision, medically-necessary services which were previously not covered by Medi-Cal are now to be deducted by the facility from a patient's share of cost. Thus, family members and patients alike no longer have to be burdened by extra charges for necessary services.

Nursing homes, understandably, want to receive the payment which is due them each month. I believe there are mechanisms for guaranteeing this without resorting to the extreme device of holding someone other than the patient personally liable for any and all charges, which most admissions agreements presently do.

1. Patients on private pay status should pay the agreed-upon rate each month. Even if another person assists them with paying bills, however, it should be the patient's assets which pay for his or her care, not the assets of the helping person.

2. If a helping person fails to pay a patient's bill with the patient's money (either the full bill for private patients or the share of cost for Medi-Cal patients), it would be reasonable to ask said patient to agree to a direct deposit mechanism, making his money available for his own needs. Misuse of a patient's money by any outside individual should be promptly investigated.

3. Title 22 already provides that patients can be discharged for nonpayment of stay. This is certainly a protection for the facility.

4. If a patient is under conservatorship, the conservator is obligated to pay the patient's bills from the patient's own assets. The Crestwood Corporation uses a conservator's agreement which states, quite reasonably, "...the undersigned Conservator agrees with the facility and its assigns that payment will be made out of the Conservatee's assets of all charges incurred by or on behalf of patient at said facility. If not qualified for Medi-Cal or Medicare, the Conservatee's assets will be responsible for payment of the bill."

5. Once the assets of a patient on private pay status are diminished to the level of Medi-Cal eligibility, Medi-Cal payment plus the calculated share of cost should be accepted as payment in full. The share of cost should be taken from the patient's income, not from an outside individual's income. Direct deposit or the use of a representative payee can be helpful when the patient is not declared incompetent by a court of law, yet needs help with paying bills.

6. An outside person can indeed be helpful to both a patient and the facility by (a) agreeing to be the person to call in case of emergency, and (b) agreeing to assist the patient in paying necessary bills, using the patient's assets. To ask this outside person to accept the responsibility of becoming personally liable for charges, however, is to carry the idea of the Good Samaritan too far.

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December 10, 1986

Senator John Heinz
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

Earlier this year, I discussed with David Schulke of your staff, a research project I am conducting with support from the Retirement Research Foundation. My research on state regulation of nursing homes has shown that very little information is available regarding the states' use of intermediate sanctions.

In October of 1986, I was able to obtain from each state survey agency information on both the types of sanctions permitted in the state and the number of times each sanction was used in the past year.

I would like to offer for inclusion in the record of your hearing a report detailing these findings. The report was prepared for presentation at a Conference sponsored by the Gerontological Society of America. Complete findings from my research will be published in a book at the end of 1987.

Yours truly,

John A. Gardiner
Professor

COPS, CONSULTANTS, AND GOLDFISH

VARIATIONS IN NURSING HOME REGULATION

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This paper is based on research funded by the Retirement Research Foundation; findings and conclusions are those of the author and are not necessarily shared by the Foundation.

Every agency which enforces nursing home regulations is exposed to pressures by nursing home residents, their friends and families, and organized advocacy groups to "get tough" on the nursing home industry. Each agency is also subject to industry pressure to be "flexible" in its interpretation of regulations, to be "understanding" in setting timetables for plans of correction, and to act as a "consultant" rather than as a "cop." Each agency is frustrated by difficulties in ensuring that field inspectors carry out central office policies and priorities, by lawyers and judges who find "professional judgment" an inadequate basis for proposed penalties, and by elected officials who craft inconsistent policies and/or call for get-tough policies while they seek breaks for individual constituents or relatives.

While every regulatory system is thus subjected to many divergent pressures, these pressures may not be of equal strength in each state, and the regulators may reconcile conflicting pressures in different ways. To simplify the possibilities, one state's regulators might see themselves as "cops," citing every violation they see, while another state might emphasize a "consultant" role, emphasizing a facility's prompt return to compliance with regulations rather than citations and fines. Other states have directly or indirectly abandoned enforcement strategies and turned to incentives in the hope that the promise of more money will appeal to nursing home operators who have not been deterred by the threat of penalties. (Sceptics in Illinois believe that incentive payments for a "functional and sensory-stimulating environment" have simply led nursing homes to put a tank of goldfish in the day room.) Finally, it can only be said that some states have no coherent policy, mumbling platitudes about "high quality care" while muddling along with minimal resources, no follow-through, and a ready willingness to agree with whoever is complaining the loudest.

Measuring Policy Variations. For twenty years, the nursing home industry has charged that the regulators behave like mindless cops, finding insignificant violations in the shape of place mats, the temperature of fishtanks, and the completion of records that no one reads. Conversely, a series of state investigations, books, and reports by resident advocates have concluded that most regulatory agencies act like spineless consultants, gullibly acceding to whatever promises of compliance are made at the end of a survey. While each side has numerous anecdotes to support its conclusions, it has never been possible to compare state agencies' enforcement policies. Industry and advocates believe that there are significant differences among the states--that a nursing home offering a certain quality of care will be licensed in State X, but that an identical home will be put out of business in State Y; or that two different homes will receive the same treatment by different agencies. Ultimately, validation of these claims is impossible: the only "evidence" of conditions in nursing homes lies in the reports written by the regulators. Two annual surveys which conclude that facilities are in compliance with a nursing care standard, are indistinguishable; two surveys which conclude that one facility is in compliance while the other is not, cannot be deciphered to determine whether the care given in the first facility is "really" better than the care in the second. Just as we have no independent measures of the quality of care, we have no measures of the impact which enforcement has had on regulated nursing homes: one regulatory agency may be able to induce compliance with a friendly word of advice or a stern (but informal) warning, while another agency may impose penalties with abandon but be ignored by the regulated facilities.

Accepting these limitations, a survey of state nursing home licensure and certification agencies conducted in October of 1986 provides an opportunity to identify rough variations in enforcement practices and the factors which tend to correlate with "tough" and "lax" enforcement styles. Each agency was asked both what sanctions it could impose on facilities which violate state or federal regulations, and how many times it had used each sanction in the past year (calendar 1985 or fiscal 1986). The results of the survey are shown in Table One. The sanctions reported varied in a number of ways. Some (monitors and receivers) restricted the facility's freedom to operate, but did not by themselves have financial consequences. Some forced a total cessation of operations (relocation of residents, license revocation), while others produced financial penalties in varying amounts (fines, bans on admissions, reduced or withheld Medicaid reimbursement).

	CERTIFIED SNF AND ICF FACILITIES	TOTAL SANCTIONS IMPOSED, 1985-86	SANCTIONS PER FACILITY	CIVIL OR ADMIN-ISTRATIVE FINES	COURT-APPOINTED RECEIVER	STATE-APPOINTED MONITOR	SUSPENSION OF ALL NEW ADMISSIONS	SUSPENSION OF MEDICAID ADMISSIONS	REJECTING CON FOR PAST RECORD	COURT INJUNCTION	RELOCATION OF RESIDENTS	REDUCED MEDICAID RATES	RESTRICTED LICENSE	LICENSE REVOCATION	LICENSE SUSPENSION	INVOLUNTARY DECERTIFICATION	WITHHOLDING MEDICAID REIMBURSEMENT
AL ALABAMA	212	20	.09	X	X	X	0	0	X	1	4	X	6	0	1	4	4
AK ALASKA	12	2	.17	X	X	0	X	X	X	X	X	X	2	0	0	0	X
AZ ARIZONA	73	79	1.08	2	X	X	15	X	X	0	6	X	48	2	2	4	X
AR ARKANSAS	214	69	.32	57	X	X	4	4	X	X	2	X	X	1	0	X	1
CA CALIFORNIA	1,379	2,161	1.57	2,081	1	0	0	0	0	2	12	0	4	19	2	21	19
CO COLORADO	182	7	.04	X	0	2	2	0	0	0	0	X	3	0	0	0	X
CT CONNECTICUT	232	6	.03	0	0	5	0	0	0	X	0	X	X	0	0	1	X
DE DELAWARE	31	7	.23	X	0	X	1	0	0	X	X	X	4	1	0	X	1
DC DIST OF COLUMBIA	12	10	.83	X	0	2	2	0	1	X	1	X	2	1	X	1	X
FL FLORIDA	363	186	.51	70	0	0	8	0	0	0	0	X	108	0	0	0	0
GA GEORGIA	323	26	.08	0	X	1	X	19	0	0	2	X	0	0	0	4	X
HI HAWAII	33	0	.00	0	X	X	X	X	X	X	X	X	0	0	0	0	X
ID IDAHO	62	5	.08	X	X	X	X	1	X	X	X	X	4	0	X	0	X
IL ILLINOIS	723	112	.15	61	0	13	X	15	0	0	2	X	16	0	0	5	0
IN INDIANA	460	54	.12	2	0	20	X	0	0	X	1	X	25	1	X	5	X
IA IOWA	423	42	.10	35	0	X	X	X	X	X	0	X	5	1	0	1	X
KS KANSAS	370	81	.22	12	0	1	X	X	X	X	1	X	60	7	X	0	X
KY KENTUCKY	209	16	.08	12	X	X	X	X	0	0	1	X	X	2	0	1	X
LA LOUISIANA	238	53	.22	3	0	0	0	2	0	0	0	X	45	1	X	2	0
ME MAINE	144	3	.02	0	0	X	0	0	0	0	1	0	0	1	X	1	0

	CERTIFIED SNF AND ICF FACILITIES	TOTAL SANCTIONS IMPOSED, 1985-86	SANCTIONS PER FACILITY	CIVIL OR ADMIN-ISTRATIVE FINES	COURT-APPOINTED RECEIVER	STATE-APPOINTED MONITOR	SUSPENSION OF ALL NEW ADMISSIONS	SUSPENSION OF MEDICAID ADMISSIONS	REJECTING CON FOR PAST RECORD	COURT INJUNCTION	RELOCATION OF RESIDENTS	REDUCED MEDICAID RATES	RESTRICTED LICENSE	LICENSE REVOCATION	LICENSE SUSPENSION	INVOLUNTARY DECERTIFICATION	WITHHOLDING MEDICAID REIMBURSEMENT
MD MARYLAND	190	31	.16	X	0	X	4	X	0	0	X	X	25	2	0	0	0
MA MASSACHUSETTS	512	101	.20	X	5	3	15	5	0	2	4	42	14	5	1	5	X
MI MICHIGAN	429	130	.30	50	1	X	1	1	X	0	0	65	0	4	0	8	X
MN MINNESOTA	466	34	.07	34	0	X	0	0	X	0	0	X	X	0	0	0	X
MS MISSISSIPPI	152	2	.01	X	X	X	0	0	0	X	0	0	2	0	0	0	0
MO MISSOURI	304	66	.22	0	1	3	5	0	0	3	0	X	18	31	0	5	X
MT MONTANA	92	0	.00	0	X	X	X	X	0	X	0	0	0	X	X	X	X
NE NEBRASKA	216	17	.08	X	1	X	6	0	0	X	0	X	10	0	0	0	X
NV NEVADA	27	2	.07	X	X	X	X	2	0	X	0	X	X	0	0	0	X
NH NEW HAMPSHIRE	70	3	.04	X	X	X	X	X	X	1	X	X	2	0	0	0	X
NJ NEW JERSEY	242	49	.20	28	2	X	15	0	0	X	2	X	0	0	2	0	X
NM NEW MEXICO	53	0	.00	X	X	X	X	0	X	X	0	X	0	0	0	0	X
NY NEW YORK	583	159	.27	85	8	X	0	7	50	0	0	X	0	8	0	1	X
NC NORTH CAROLINA	227	37	.16	23	X	X	5	X	2	0	0	X	6	0	0	1	X
ND NORTH DAKOTA	82	1	.01	X	X	X	1	X	X	X	X	X	X	0	X	0	X
OH OHIO	879	20	.02	X	X	X	0	18	0	0	0	X	X	0	X	2	X
OK OKLAHOMA	'369	7	.02	X	2	0	0	2	0	0	0	2	0	0	0	1	0
OR OREGON	182	118	.65	102	3	0	X	8	0	0	2	0	X	2	X	1	0
PA PENNSYLVANIA	608	131	.22	12	X	2	19	0	0	1	4	X	82	9	X	0	2
RI RHODE ISLAND	107	2	.02	0	X	X	1	1	0	X	0	X	X	0	0	0	X

	CERTIFIED SNF AND ICF FACILITIES	TOTAL SANCTIONS IMPOSED, 1985-86	SANCTIONS PER FACILITY	CIVIL OR ADMINISTRATIVE FINES	COURT-APPOINTED RECEIVER	STATE-APPOINTED MONITOR	SUSPENSION OF ALL NEW ADMISSIONS	SUSPENSION OF MEDICAID ADMISSIONS	REJECTING CON FOR PAST RECORD	COURT INJUNCTION	RELOCATION OF RESIDENTS	REDUCED MEDICAID RATES	RESTRICTED LICENSE	LICENSE REVOCATION	LICENSE SUSPENSION	INVOLUNTARY DECERTIFICATION	WITHHOLDING MEDICAID REIMBURSEMENT
SC SOUTH CAROLINA	131	1	.01	1	x	x	x	x	0	0	0	x	0	0	0	0	x
SD SOUTH DAKOTA	117	28	.24	0	0	x	0	2	x	0	0	x	26	0	0	0	x
TN TENNESSEE	248	33	.13	x	x	12	14	x	x	0	0	x	4	1	1	1	0
TX TEXAS	965	450	.47	0	2	x	x	x	x	0	3	x	x	1	0	117	327
UT UTAH	77	3	.04	x	x	x	x	1	x	0	x	x	1	0	0	1	x
VT VERMONT	45	4	.09	0	x	x	0	0	x	x	0	x	4	0	0	0	x
VA VIRGINIA	179	4	.02	x	x	x	2	0	x	0	x	x	x	1	0	1	x
WA WASHINGTON	277	26	.09	7	x	x	14	0	1	x	0	x	x	1	1	2	0
WV WEST VIRGINIA	92	18	.20	0	x	x	x	0	x	0	0	6	10	1	0	1	0
WI WISCONSIN	430	137	.32	136	0	0	x	x	x	0	0	x	0	0	x	1	x
WY WYOMING	27	2	.07	x	x	x	x	1	x	x	0	x	0	0	0	1	x
TOTALS	14,073	4,555	.32	2,813	26	64	134	89	54	10	48	115	536	103	10	199	354
NO. OF STATES WITH SANCTION	----	----	----	31	25	18	31	36	29	30	42	9	39	50	39	48	17

Notes to Table One

As indicated in the Appendix, these data were collected by means of telephone interviews with the licensure and certification agencies in each state and the District of Columbia; the interviews were conducted in October of 1986. If the agency indicated that it did not have data on all sanctions, additional calls were made to the state's Medicaid agency and/or health planning agency. Information provided by the agencies was questioned in only two aspects: they were asked to report only sanctions which had been imposed, not just threatened, and each assault on a facility was to be listed only once (e.g., if the facility lost its license and thereby lost its certification to participate in Medicaid, the event was reported only under license revocation.) These data, and the labeling guidelines which were used, were given back to the states for correction.

x = this sanction is not available in the state.
0 = this sanction is available, but was not used during the year.
"Certified SNF and ICF facilities" = the unduplicated total number of certified skilled nursing facilities and intermediate care facilities (but not ICF/MRs) certified by HCFA in 1984. Data supplied by HCFA.
"Total Sanctions Imposed 1985-86" = the sum of the individual sanctions. States were asked to provide data for the most recent twelve month period possible; some used calendar 1985 and some used FY 1986.
"Sanctions per Facility" = the second column divided by the first column.
"Civil or Administrative Fines" = fines imposed on a facility for violating a statute or regulation. (N.B. this does not include fines imposed on an individual, such as a doctor or aide, working in a nursing home.)
"Court-appointed receiver" = a formal order designating someone to operate a nursing home under court supervision (often during sale or closing of the facility.)
"State-appointed monitor" = a representative of the survey agency or Medicaid agency assigned to scrutinize facility compliance with a plan of correction or performance following a negative survey.
"Suspension of all new admissions" = formal order by the licensing agency not to admit any new residents until specified conditions have been met.
"Suspension of Medicaid admissions" = notification by the Medicaid agency or licensing agency that no new admissions will be covered by the Medicaid program until further notice. (Unless all admissions are banned, however, a facility could still admit new private pay residents.)
"Rejecting CON for Past Record" = An action by the state's health planning agency rejecting an application for a Certificate of Need because the applicant had previously violated long-term care regulations.
"Court Injunction" = a formal order by a court enjoining the facility from future violations.
"Relocation of Residents" = formal action by the state removing residents from a facility, usually undertaken only in life-threatening situations.
"Reduced Medicaid Rates" = reductions in the rate at which a facility participating in Medicaid is reimbursed, because of rule violations.
"Restricted License" = the facility may operate, but under restrictions resulting from previous poor performance (not including probationary licenses automatically issued to new licensees.)
"License Revocation" = involuntary termination or non-renewal of a facility license.
"License Suspension" = short-term loss of license to operate.

"Involuntary Decertification" = involuntary termination or non-renewal of certificate to participate in the Medicaid or Medicare programs.

"Withholding Medicaid Reimbursement" = temporary or permanent decision to deny payment for Medicaid residents already in a facility, due to violation of regulations.

Without implying that these sanctions are of equal significance, Table Two summarizes the total number of sanctions imposed by each state.

TABLE TWO
NURSING HOME SANCTIONS IMPOSED, 1985-86

Number	States
0-10	Alaska, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Maine, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, Utah, Vermont, Virginia, Wyoming
11-30	Alabama, Georgia, Kentucky, Nebraska, Ohio, South Dakota, Washington, West Virginia
31-50	Iowa, Maryland, Minnesota, New Jersey, North Carolina, Tennessee
51+	Louisiana (53), Indiana (54), Missouri (66), Arkansas (69), Arizona (79), Kansas (81), Massachusetts (101), Illinois (112), Oregon (118), Michigan (130), Pennsylvania (131), Wisconsin (137), New York (157), Florida (187), Texas (450), California (2,161)

As a rough device to control for the number of nursing homes which the agencies must regulate,[5] Table 3 groups the states by the number of sanctions per 100 skilled or intermediate care facilities certified to participate in Medicaid or Medicare.

TABLE THREE
SANCTIONS PER 100 CERTIFIED NURSING HOMES, 1985-86

Number	States
0-5	Colorado, Connecticut, Hawaii, Maine, Mississippi, Montana, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Utah, Virginia
6-10	Alabama, Georgia, Idaho, Iowa, Kentucky, Minnesota, Nebraska, Nevada, Vermont, Washington, Wyoming
11-20	Illinois, Indiana, Maryland, Massachusetts, New Jersey, North Carolina, Tennessee, West Virginia
21+	Kansas (22), Louisiana (22), Missouri (22), Pennsylvania (22), Delaware (23), South Dakota (24), Alaska (25), New York (27), Michigan (30), Arkansas (32), Wisconsin (32), Texas (47), Florida (51), Oregon (65), District of Columbia (83), Arizona (108), California (157)

No reservations about the interpretation of these data can obscure some of the greater contrasts which are displayed in these tables: between Texas, which imposed 450 sanctions in regulating its 965 facilities, and Ohio, imposing twenty sanctions on 879 facilities; between Florida (186 sanctions, 363 facilities) and Georgia (26 sanctions, 323 facilities); or between Oregon (102 fines, 118 facilities) and Washington (7 fines, 277 facilities). Texas decertified 117 facilities; twenty states decertified *none*. Fifteen states imposed five or less sanctions per 100 nursing homes; sixteen imposed twenty-one or more (Table Three).

Correlates of Enforcement Policies. To the extent that the data on the total number of sanctions imposed, and the number of sanctions per 100 certified facilities, are indicators of state enforcement policies, are they correlated with other characteristics of the states? This paper reports a preliminary analysis of several aspects of this questions.

Three broad categories of variables will be discussed. (Precise definitions of each variable, and their sources, are reported in the notes to Table Four.) The first consists of *variables relating to nursing homes and the elderly in each state*. They are the number of certified SNFs and ICFs in the state, the number of nursing home beds per 1,000 persons 65 and over, the occupancy rate of nursing home beds, SNF reimbursement rates, and the percent of the state's population which is 65 and over. A second set of variables concerns *social or political issues*: party identification, state funding for the Medicaid program, and general liberalism. The final set are *bureaucratic* variables: total expenditures for the state's nursing home survey program, the number of FTE surveyors per facility, and the total number of sanctions (fines, receiverships, etc.) which are available to the state agency. Table Four shows the correlations among all of these variables.

Several statistically *insignificant* findings are surprising. While it has often been argued that regulators are unable or unwilling to take action against substandard nursing homes because of high *occupancy rates* (i.e., because there were no vacant beds to which residents could be transferred), Table Four shows virtually no correlation (Pearson's r= -.0033) with Total Penalties and little with Penalties/Facility (-.1863). Similarly, despite the expection that states which pay higher Medicaid reimbursement rates would demand higher quality, the correlations are similarly low (-.0725, -.2111). With reference to the three indicators of policy liberalism (Democratic party identification, state Medicaid funding, and Klingman and Lammers' "general policy liberalism"), correlations with the total number of penalties are generally low (.0866, .1339, .2519); the correlations with Penalties/Facility are somewhat higher (.2359, .3355, and .1405).

TABLE FOUR

CORRELATION MATRIX: NURSING HOMES, LIBERALISM, ENFORCEMENT SYSTEMS, AND PENALTIES

	STATE POPULATION	CERTIFIED FACILITIES	BEDS/ POPULATION	OCCUPANCY RATE	SNF REIMBURSEMENT	PER CENT OVER 65	DEMOCRATIC IDENTIFICATION	MEDICAID FUNDING	LIBERALISM	SURVEY COSTS	SURVEYORS PER FACILITY	AVAILABLE SANCTIONS	TOTAL PENALTIES
CERTIFIED FACILITIES	.9010												
BEDS/POPULATION	-.1030	.2095											
OCCUPANCY RATE	-.0353	-.1171	-.0495										
SNF REIMBURSEMENT	-.0734	-.1418	-.0950	.0099									
PER CENT OVER 65	.0731	.1401	.2303	.2755	-.2692								
DEM IDENTIFICATION	.1098	.0488	-.2828	-.0122	-.1850	-.1863							
MEDICAID FUNDING	.2877	.2323	.0561	.0743	.3762	.1393	-.0778						
LIBERALISM	.3494	.3594	.2193	.1756	.3503	.1997	-.4699	.7181					
SURVEY COST	.6957	.4825	-.1901	.0605	.0853	.2907	.0377	.3212	.2681				
SURVEYORS/FACILITY	-.1253	-.2337	-.2838	-.0676	.2913	-.0105	.2053	.5843	.0421	.0302			
AVAILABLE SANCTIONS	.5254	.4437	-.1159	.2042	-.2375	.3442	.2763	.2511	.2731	.4665	.0086		
TOTAL PENALTIES	.7149	.7105	-.0690	-.0033	-.0725	-.0322	.0866	.1339	.2519	.3944	-.0932	.3808	
PENALTIES/FACILITY	.5082	.4452	-.2605	-.1863	-.2111	.0562	.2359	.3355	.1405	.3447	.2670	.4183	.7427

Notes to Table Four

"State Population" = state population in 1980 census.

"Certified Facilities" = certified SNF and ICF facilities in 1984 (see Table One)

"Beds/Population" = nursing home beds in 1983/1000 population aged 65 and over (Source: Institute of Medicine, 1986:361)

"Occupancy Rate" = percent of all (licensed and unlicensed) nursing home beds occupied (Source: 1982 National Master Facility Inventory, Table 24)

"SNF Reimbursement" = Average Medicaid Rate per Patient Day, FY 1983 (Source: HCFA, 1984: 106)

"Per Cent over 65" = Percentage of 1981 State Population 65 years and over (Source: Institute of Medicine, 1986: 369)

"Democratic Identification" = percentage of state respondents to CBS/ New York Times surveys 1976-1982 identifying themselves as Democratic (Source: Wright, 1985: 476)

"Medicaid Funding" = the state share of Medicaid payments in FY 1983, divided by the state's population (Source: HCFA, 1984:145)

"Liberalism" = General policy liberalism score developed by Klingman and Lammers (1984:602-3) aggregating six indicators of innovativeness, anti-discrimination, AFDC payments, Title XX payments, speed of ratification of Equal Rights Amendment, and consumer-oriented policies.

"Survey Cost" = total state survey agency licensure and certification expenditures, FY 1983 (Source: Institute of Medicine, 1986: 330)

"Surveyors/Facility" = state survey agency FTE employees in 1984 engaged in licensure and certification activities (Source: Institute of Medicine, 1986: 331) divided by the number of certified facilities. (N.B. seven states did not supply this data for the IOM survey, but supplied it in the course of our 1986 telephone survey).

"Available Sanctions" = the total number of sanctions which states can impose on nursing homes (see Table One).

"Penalties/Facility" = Sanctions per Facility from Table One

By far the strongest correlations with Total Penalties and Penalties/Facility involve the variables which deal with the magnitude of the regulatory workload and the resources available to handle it: with *state population* (.7149, .5082), with the number of *certified SNFs and ICFs* in the state (.7105, .4452), with the *costs of the survey program* (.3944, .3447), and with the *number of available sanctions* (.3808, .4183); the number of *surveyors per facility* was moderately correlated with the number of penalties per facility (.2670) but not with the total number of penalties (-.0932).

To sort out the contributions of these variables, all were included in stepwise regression analyses of the two dependent variables. From each analysis, a model containing not more than three significant variables emerged.

$$\begin{aligned} \text{TOTAL PENALTIES} = -582 &+ .4203\ \text{CERTIFIED FACILITIES} \\ &\qquad\qquad (1.57) \\ &+ .00002\ \text{STATE POPULATION} \\ &\qquad\qquad (1.62) \\ &+ 4.9027\ \text{OCCUPANCY RATE} \\ &\qquad\qquad (.54) \end{aligned}$$

$$R^2 = .5362$$

$$\begin{aligned} \text{PENALTIES/FACILITY} = -.23 &+ .0005\ \text{CERTIFIED FACILITIES} \\ &\qquad\qquad (3.24) \\ &+ .5083\ \text{SURVEYORS/FACILITY} \\ &\qquad\qquad (3.07) \\ &+ .0259\ \text{AVAILABLE SANCTIONS} \\ &\qquad\qquad (1.74) \end{aligned}$$

$$R^2 = .3824$$

In other words, the total number of penalties imposed in a state is strongly related to the state's population and total number of nursing homes. The occupancy rate adds very little to the regression equation (there was a 59% probability that this number would occur by chance.)

The penalties/facility equation suggests three interpretations:

1) Agencies which regulate more nursing homes tend to act more formally, i.e., by imposing sanctions rather than "working with" facilities to bring them into compliance.

2) Enforcement policies may be reflections of staff resources: to the extent that imposing a penalty involves additional work, the agencies with a higher surveyor/facility ratio may be more *able* to penalize.

3) The availability of additional sanction alternatives may make the states more willing to act (or the facilities less interested in resisting) than if the only option is the drastic step of delicensure or decertification. (Table One, for example, shows that in almost every state, the vast majority of penalties are fines or restricted licenses; overall, they constitute 74% of the penalties imposed in 1985-86.

Policy Implications. Analyzing state enforcement policies on the basis of the types of data used here is both scientifically risky and substantively debatable. As is detailed in the Appendix, a state may take many steps to enforce its nursing home regulations *without* invoking the penalties studied here; and consultation and other forms of informal suasion may well be very effective. To the extent that formal actions -- penalties -- *are* deemed to be necessary components of a state's enforcement program, however, this analysis has several policy implications. While the regression analyses suggest that the states with few nursing homes will be unlikely to adopt "cop" styles, the larger states may be more likely to impose sanctions if they have larger staffs and more sanctions to choose from. Unlike the Wizard of Oz, it is impossible to *order* a regulator to be courageous, but it is possible to provide the staff and armaments which will make courage efficacious.

NOTES

1. I wish to thank Val Poliny and Leta Dally for their assistance in the collection and analysis of the data used in this report, and Mary Lou Mendoza for her assistance in preparing the manuscript.
2. Similarly, it is widely accepted that there are substantial variations among surveyors working in the same agency, and between surveys of the same facility in different years.
3. The limitations inherent in attempts to measure quality of care and enforcement activities are analyzed in detail in the Appendix.
4. Every state has an agency (often part of the health department) which determines whether a nursing home complies with state licensure requirements. If the facility wishes to participate in the Medicaid and/or Medicare programs, the agency also surveys to determine whether it meets federal requirements; annually, the agency must certify to the Health Care Financing Administration that the facility is in compliance with standards or is in the process of attaining compliance.
5. In addition to the certified SNFs and ICFs, the agencies also regulate certified facilities for the mentally retarded and uncertified facilities, and look for unlicensed facilities.

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APPENDIX

MEASUREMENT ISSUES IN THE STUDY OF REGULATORY ENFORCEMENT

> I have endeavored to sum up the
> evidence upon the case, as fairly as I can;
> and the result seems to be, that the world
> must vibrate in a state of uncertainty
> as to what was the truth.
>
> Boswell (1904:127)

This study has been based upon a variety of sources of information about nursing home regulatory practices; I hope that it accurately depicts the diversity of forces that influence the regulatory process. Even if I have achieved that goal, however, the reader must understand that virtually no systematic, nationwide "objective" information exists about the enforcement of nursing home regulations. Nothing is known about "real" conditions in nursing homes, about the criteria used by regulators to evaluate those conditions, or about informal coercive measures used by them to attain compliance. This Appendix discusses the sources of this information shortage, and its implications for research efforts.

I. *Violation-Detection Systems*. In an extensive survey of the sources of data on "white-collar law-breaking", Albert J. Reiss, Jr., and Albert D. Biderman noted that

> How an organization comes to know about law violation depends upon its *mobilization strategies* to detect violations in its environment. The organization can rely primarily upon agents who are outside of it and who are not under its control to bring matters to its attention. Only then does it react to these matters by investigation and other forms of resource mobilization (*reactive mobilization*). An organization may also seek out violations in that environment by organizing its own modes of detection (*proactive mobilization*). One must also bear in mind that these proactive and reactive strategies of mobilization pertain to both internal and external environments of an organization, i.e., there are both *internal and external environments* and *internal and external intelligence capabilities* related to these environments. (Reiss and Biderman, 1980:108-109; emphasis in original)

Illustrating the violation-detection mechanisms available to an archetypical enforcement agency, Reiss and Biderman present the following typology:

MOBILIZATION STRATEGIES	ENVIRONMENT	
	INTERNAL	EXTERNAL
PROACTIVE	Internal AUDITS of organizational records, practices, etc.-- usually designated Audits	Reporting requirements submitted by agencies Self-reporting of violations required Audits
	Internal Inspections by monitors, tests, etc.	Monitoring systems to detect violations Inspection systems to detect violations
REACTIVE	Investigation of complaints arising internally and externally on personnel	Complaint investigation procedures on external referrals under agency mandate
	Referral for criminal prosecution	Referral for criminal prosecution

(Reiss and Biderman, 1980:112)

As has been evident throughout this study, the states vary widely in the total resources devoted to the collection of information regarding nursing homes, in their capacity (and motivation) for reacting to complaints, in their utilization of proactive data-gathering beyond the mandatory annual surveys, and in their dependence upon data *provided by* the regulated facilities. Thus they will vary in the total volume, currency (length of time since the latest on-site inspection), and breadth of information sources.

An additional source of variation arising from detection systems concerns the practice of "targeting". Some states view all nursing homes and all regulations equally, even if it means using resources to appraise facilities which have never had problems before or verify compliance with regulations which have never before been broken. Other states may target their resources on the facilities with the worst records and/or the violations which occur most frequently or have the greatest potential costs to residents. (This of course assumes that agencies *know* which facilities have the worst records, or which regulations are at greatest risk. Unfortunately, Reiss and Biderman note, most regulatory agencies' inspection "*strategies are based on presumptions that the modal violator in the system is a first rather than a repeat offender*. Because of this assumption, most information systems do not track persons [or organizations] but rather violations..." Reiss and Biderman, 1980:124-125; emphasis in original.) As a result of these variations among states in their configurations of proactive and reactive violation-detection systems, we must assume that some states know more about their nursing homes than do other states, and that some states may know (via targeting policies) more about some facilities than they do about others. What is unknown is which states are which. We do not know that State X ignores complaints, that State Y ignores all regulations unrelated to nursing care, that State Z has a "hit list" of facilities it wishes to drive out of business. When we see, therefore, statistics on the number of violations cited by each state, or the number of penalties imposed, we do not know whether they mirror differences in the nursing homes' quality of care, or differences in detection systems; one state may cite many violations because it investigates more often or more thoroughly or more efficiently (looking where violations might be expected), while another state may have few violations simply because it was not looking in ways which would uncover problems. Finally, reiterating the last comment from the Reiss and Biderman study, the emphasis in most information systems on violations rather than violators means that researchers and policy-makers can't ask, across state lines, whether certain characteristics of facilities (size, age, ownership, case-mix, etc.) are related to care; the detection-system variations will obscure any relationships which may exist.

II. Inter-Agency Data Issues. The task of regulating nursing homes is shared by many agencies in each state, including the licensing and certification agency, the Medicaid agency, the agency which grants professional licenses for nurses and administrators, and the Attorney-General. Each of these agencies maintains its own information system. Within each agency, separate information systems may track the efforts of sub-units -- surveyors, complaint investigators, attorneys, etc. Reiss and Biderman term these information systems "disjunctive." "It is characteristic of these information systems that they are discretely organized, each around its own set of cases, that only a minimum of information is exchanged when a case is an output transaction to another organization and that often no attempt is made to track a case beyond its point of transfer to another organization. When it is tracked, each organization records its own information about 'the case.'" Among the consequences of this disjunctiveness, they note, are information-processing based on cases rather than the people or organizations being regulated (thus ignoring information which might explain behavior); interorganization linkage through networks rather than systemic properties (thus precluding analysis of the flow of cases through the entire system); differential, and frequently incomplete, information about matters unrelated to a specific decision; and inability to compare conduct across organizations. (Reiss and Biderman, 1980: 133-134)

I have previously noted the varying priorities of these agencies -- some may want to maximize quality of care, some may want to maximize beds available to welfare recipients, some may want to maximize public visibility (a splashy courtroom victory), some may want to minimize effort, etc. Because of these differences in priorities, the agencies' information systems will contain different data. They will not only record different subject matter (vacant beds, Medicaid accessibility, infection control, court calendars, and so forth), but they will vary in the extent of their coverage: some may deal only with current cases (Should nurse Jones lose her license? Should Restful Hills be fined $1,000?), while others will amass histories of the performance of a facility or professional.

Even if (which is not always the case) the agencies wish to assist each other in the execution of their duties, these information system disjunctions will mean that they can't. None of the agencies can "push a button" and call up the collective knowledge of all agencies. I refer not simply to the lack of shared computers; they organize, process, and store (if at all) information differently. With regard to the same facility, the survey agency will "know" that it had twelve "C" violations, the Medicaid agency will know that 78 residents are receiving care at the skilled level, the licensing agency will know that delicensed Nurse Jones used to work there, and the Attorney General will recall a resident abuse case dismissed for lack of evidence. Staff members may be able to tap their collective memories, but no more systematic synthesis is possible.

A final aspect of this inter-agency issue concerns each agency's operating routines. Quite simply, few regulators even check to see whether another agency may have relevant information. Prior to conducting an annual survey, the survey agency does not ask the Medicaid agency if the facility's most recent Inspection of Care reports were satisfactory, or ask the professional licensing agency if there have been complaints about the staff, or ask the Attorney General if charges are being investigated. As outlined above, no two agencies define things similarly, but they don't make efforts to share what they do know.

III. Discretion in Labeling. "A principal source of variability in collecting information lies in the discretion of officials to determine the threshold of what it is about information that opens it to treatment as a potential violation of law. . . The critical decision in accessioning matters for any agency is what is to be made a matter of record. . . What will be treated as a matter of record within an agency will depend upon criteria and decisions about what matters have a future course within the organization in the sense that some resources will be devoted to them, even if only superficially, rather than their being referred elsewhere." (Reiss and Biderman, 1980: 144-145, emphasis in original.)

With regard to labeling nursing home violations, agencies and surveyors have wide discretion regarding when and what violations will be recorded. Regarding the timing of a formal label of deficiency, policies and practices vary enormously, both among states and among surveyors. A non-compliant situation could be labeled (officially designated) (1) as soon as an inspector observes it, (2) if it remains non-compliant when the inspector is about to leave a facility, (3) if the inspector's supervisor concurs in the labeling, (4) if the agency director concurs, (5) if some external agent concurs (a hearing officer, a judge, etc.), or any combination of these. Some agencies may keep statistics based on the initial appraisal of non-compliance (the survey, the complaint investigation), while others may only store information on the events which survive screening. With regard to facilities seeking initial licensure or re-licensure, some agencies may withhold the license until compliance is achieved, while others may license "subject to a plan of correction." In summary, violation data from one state may "look bad" (showing many deficiencies in many facilities) simply because it reports everything ever observed, while another state may report only those problems remaining after an opportunity to correct and an agency review process.

The participants in debates over nursing home issues have defined quality care in different ways. Some emphasize physical issues -- building safety, sanitation, and so forth, while others focus on health issues -- is the resident receiving the medical and nursing care appropriate to his or her condition? More recently, nursing home advocates have tried to focus attention on the "quality of life" -- whether, as Bruce C. Vladeck summarizes the issue, "the food is palatable and tasty as well as minimally nutritious; whether the facility is clean and pleasant; whether there are activities that truly engage the residents' interest as well as meeting formal regulatory requirements; most crucially, perhaps, whether the paid staff are nice to and caring about the residents." (Vladeck, 1980:356)

The enforcement data collected and stored by a survey agency may address all of these issues. It is more likely, however, that the data are selective and non-representative, emphasizing and de-emphasizing things the agency and the surveyor feel are more and less important.

1) Visits by regulatory agencies to individual nursing homes are usually very infrequent. Unless an agency uses the Inspection of Care program as an opportunity for virtually continuous on-site monitoring of care, or investigates complaints frequently, it will only observe conditions once or twice per year, often on a schedule predictable to the facility. Furthermore, almost all inspections are conducted between 9:00 a.m. and 5:00 p.m., between Monday and Friday. Unless the agency has decided to declare war and conduct a midnight raid, it will know nothing about what happens nights and weekends.

2) While this is changing to some extent under the LTCSP survey system inaugurated in 1986, most of the on-site efforts of inspectors are concerned with procedural matters and detailed examination of a few residents most likely to have been treated poorly. The LTCSP sampling process provides more information than its predecessor, but does not try to identify the distribution of levels of quality (the proportions of excellent, adequate, and substandard care); unless investigation identifies a specific instance of deficient care, everything is assumed to be acceptable. The process, in other words, is oriented toward the detection of failures rather than the measurement of "normal" quality. A regulatory agency may be able to report that a nursing home abused a resident or failed to care for her condition; it cannot say whether in other respects the home is outstanding or merely acceptable.

3) The measurement tools applied by inspectors are better equipped to assess physical or medical issues than quality of life issues. Whether because of the "minimum standards" origins of regulation, or because of the fear of litigation, or because of the backgrounds of many regulators, the emphasis has been on things that can be more readily measured and written down. Vladeck's desiderata of "tasty" food, "pleasant" surroundings, "interesting" activities, and "caring" staff members can be assessed, but the current routines of inspectors do not do so.

4) The most important reason why we do not know, in any uniform sense, what quality of care is being provided in each state is that the data which are available are fundamentally reflections of regulatory policy. We do not know that a nursing home is doing a good job treating stroke and a poor job treating dementia; we have instead a regulator's report that the home is or is not complying with a regulation. The state surveyors may have very different beliefs as to what care is appropriate, and they (and/or their supervisors) may have very different norms as to when the care being offered is sufficiently "deficient" to be reported. The same objective conditions may be regarded as acceptable by Inspector A, deficient but meriting only oral admonishment by Inspector B, or worthy of an official violation notice by Inspector C. The third action may be overruled by a supervisor or judge; the first two actions are almost never scrutinized. We are left with data, as a result, which show that one nursing home was cited for a deficiency and the next nursing home was not; we do not know whether they were of equal quality.

5) Finally, regulators act in different ways after they conclude that a deficiency exists. By some process which may be influenced by official guidelines (written or unwritten), conclusions are reached as to the "seriousness" of the violation, and the regulators will translate some of the perceived deficiencies into a set of written records. In some states, a report may cite one instance of a failing (Jane Smith's dressing was

unchanged), while other states will label every instance as a separate violation (10:00 p.m. medications were not given to Jane Smith, Mary Jones, or Pat Brown, on Tuesday, Wednesday, or Thursday.) The first would appear as one violation, the second would be nine.

A second variation concerns the level of generality cited. The forms used in HCFA certification surveys permit a violation to be cited at the "element" or at the Standard or Condition level. (E.g., a surveyor could say that a facility failed to provide "24-hour nursing services which are sufficient to meet total nursing needs" (element F135) but not label the standard of twenty-four hour nursing service "not met.") Documenting the lack of uniformity on this issue, the Institute of Medicine's Committee on Nursing Home Regulation in 1984 asked the state survey agencies "how many standards have to be deficient for the nursing services condition to be marked 'not met'?" Only two states said "any one." Five cited specific standards which would have this consequence; 36 said "it depends." (Institute of Medicine, 1986: 338).

A third variation concerns data-retention after a problem has been corrected. If a violation has been cited -- e.g., in a survey report -- and is thereafter corrected, is it retained in some institutional memory? Some agencies will record the event as (1) a violation which was (2) corrected; other agencies will erase the record, unless it has already been reported to a court, to HCFA, or some other external body. The first type of state would appear to have facilities of poorer quality than the second's.

IV. Surveys of State Enforcement Systems. There is no national archive of information on federal, state, or local nursing home regulatory enforcement. HCFA maintains the Medicare/Medicaid Automated Certification System (MMACS), which includes some information on each nursing home certified to participate in the federal programs, but the information is often one to two years out of date. In 1986, the Inspector General of the Department of Health and Human Services reviewed case files on 1,500 nursing homes, looking at both data in MMACS and data in the state files. "All told, an average of 107 days was required -- 73 by states and 34 by HCFA -- to input the data" into MMACS. (Kusserow, 1986) (The strengths and limitations of MMACS both as a management information system and as a research resource are detailed in Blandford, 1983.) The only enforcement-related information generated by MMACS comes from the most recent survey of each facility (e.g., that a facility was not in compliance with standards A,B, and C); the data are also aggregated to the state and (federal) regional level, e.g., showing that 12% of the SNFs in Connecticut were not in compliance with standard A as contrasted with only 7% in Arkansas. MMACS shows that a July, 1986, survey found a violation of Standard X in Facility Y, but it shows nothing about the state's response to the violation (fine, receiver, plan of correction, etc.) A 1983 evaluation of MMACS records particularly cautioned against comparing data across state lines, citing variations in survey procedures, in licensing vs. certification systems (i.e., some states have more detailed licensing standards or penalization procedures, and for that reason make less use of the certification mechanisms which appear in MMACS), in survey team composition and discretionary policies, and in treatment of dual certification data. (Blandford, 1983: IV-15 -- IV-16).

HCFA does not keep records on the frequency with which states take enforcement actions against sub-standard facilities. It does, however, collect some information about the administration of state survey programs, and intermittently "validates" state surveys by sending federal surveyors into a facility shortly after a state team has left (leading to a report which says we found X but the state found Y). In an annual assessment (the Comprehensive Evaluation Report, or CER), the HCFA Regional Office critiques each state's survey activities, but the CER stresses administrative issues (especially the timeliness of state reporting to the Regional Office) and state adherence to federal policy interpretations.

Several national surveys have provided extensive information about the state survey agencies. Between 1972 and 1979, HCFA conducted four biennial surveys of state surveyors, collecting information on surveyors' backgrounds, work responsibilities, and training (HCFA, 1980). In 1983, the Association of Health Facility Licensure and Certification Directors (the heads of the state survey agencies) collected basic facts about the management of survey programs, survey procedures and finances, staffing, the facilities inspected, and involvement in other activities such as complaint investigation and certificate-of-need programs. (AHFLCD, 1983) Neither the HCFA surveyor surveys nor the AHFLCD survey collected information on enforcement policies or the use of penalties.

In 1984, as part of its comprehensive study of long-term care regulation, the Institute of Medicine Committee on Nursing Home Regulation sent an extensive questionnaire to the state survey agencies, covering the organization of their nursing home activities; agency personnel, budget workload, and training; state licensure standards; survey procedures; enforcement; and attitudes about federal regulations. The questionnaire, and a summary of the findings, are presented in Institute of Medicine (1986: Appendix C). While the IOM survey and the 1986 Report provide invaluable information about agency structures and procedures, some of the survey's data on enforcement proved limited or unreliable. Four states did not respond to the questionnaire at all, and another twelve did not answer many of the enforcement questions. More important was the fact that the states answered some questions unevenly (e.g., some would report having a sanction only if they had used it while others would report that a sanction was available to them whether used or not), and many of the survey agencies left blank questions which fell within the jurisdiction of another agency (e.g., a Medicaid agency or health planning agency.) The survey agencies' responses to the IOM questionnaire proved to be quite reliable on administrative and attitudinal issues, but the enforcement data could not be used for comparative analysis.

V. The 1986 Survey on Sanctions and Penalties. To remedy gaps in the data from the IOM survey, the data used in this analysis were gathered via a combined mail and telephone survey in October of 1986. Each survey agency was sent a two-page questionnaire; ten days later, the agencies were called to collect the information. After they reported their data, they were asked whether it included duplications (whether several penalties dealt with the same sanctioning event) and whether other agencies (e.g., Medicaid or health planning) should be contacted for additional information. After such additional leads were pursued, data was sent back to the survey agencies to check for mistakes or gaps. Each state, in other words, has seen how we have classified their data and has had an opportunity to correct it.

While we believe these data are "correct" in a quantitative sense (State X issued Y fines in 1985), they also can be very misleading. In addition to the generic problems discussed in Sections I-III of this Appendix, the following problems should be understood:

1) There is no reason to assume that the fifty-one regulatory programs are dealing with equivalent nursing homes. While statistics are available on the size and level of care (e.g., SNF vs. ICF) of each state's facilities, we

have no way of knowing whether one state's nursing home industry offers better care than another's, whether one tends to comply the moment a deficiency is cited while another waits until license revocation is threatened, etc. Thus, fundamentally, we cannot say that each state is dealing with the same regulatory task.

2) Similarly, the state's enforcement statistics in a particular year may conceal the effects of a number of historical factors. At the level of individual interactions (Pat Smith inspecting Jones Manor), the inspector may be bearing the scars of prior combat ("I got clobbered at a hearing once when I cited them for poor sanitation", or "they helped me out at the beginning when I didn't know how the regulations worked"). At a more systemic level, the nursing home industry being regulated in 1986 may have been purged of the "rotten apples" in 1976, or the agency may have learned in 1976 that aggressive policing will be frustrated in the courts or the legislature. For shorter periods of time, all inspectors may be rigid after a catastrophic nursing home fire, or timid after a publicized act of overzealousness (one state's public health director was humbled at an industry banquet by an "award" commemorating a deficiency given by one of his sanitarians; the inspector had cited a facility for having toilet paper which rolled toward the wall rather than out over the top.)

Historical influences such as these are universal -- all states experience ebbs and flows of regulatory zeal -- but it is impossible to tell where each state stands at the time of a study such as this. A state may have issued few sanctions in 1986 because it issued many sanctions in 1985 ("cleaning up the problem"), because the industry has just won a political victory, or because it doesn't believe in issuing sanctions.

3) While every state must apply the same federal certification standards, the states vary in the nature and extent of licensure requirements. The statistics reported to us may reflect varying responses to comparable expectations or they may be parallel to varying standards (one state may issue hundreds of penalties for violations of a requirement which does not exist in another state.)

4) Our telephone interviews with the states revealed many variations in state policies about when enforcement actions against a facility became "statistics," confirming a suspicion discussed in Section III, above. Some states openly reported that they "didn't bother" with sanctions until they had given up all attempts at informal suasion and were going for delicensure or decertification. Other states, by contrast, issued warning letters, fines, or even "intent to decertify" letters as soon as a survey reported a significant deficiency. Further, some states were quite ready to terminate providers who had not come into compliance within a few weeks but equally ready to re-enroll them as soon as compliance was attained. Other states were reluctant to terminate but adamant against re-enrollment.

5) Even though we asked the states to remove duplications, it is unlikely that, particularly in the more active states, every penalty recorded in Table One represents a separate event. As discussed earlier, State A may issue one penalty for a nursing care violation when State B issues separate fines for each resident neglected. Similarly, one state may issue a second penalty for a deficiency not corrected since an earlier survey, while a second state may stick with the initial penalty or even withdraw it if the problem has been corrected.

APPENDIX 2

MAY 21, 1986, COMMITTEE STAFF REPORT AND RELATED DOCUMENTS

[COMMITTEE STAFF NOTE: This Appendix consists of the May 21, 1986 staff report to the Members of the Senate Special Committee on Aging, and copies of a "response" attributed to HCFA. Also included are Committee staff analyses of the two versions of HCFA's "response" which were supplied to the Committee in October and November, 1986.]

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NURSING HOME CARE: THE UNFINISHED AGENDA

AN INFORMATION PAPER

PREPARED BY THE STAFF OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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PREFACE

The report herein contains the findings of a two-year investigation by the Special Committee on Aging into the quality of care provided in this Nation's nursing homes. Our conclusions are based on extensive interviews with patients, nursing home personnel, government officials, and other experts, in addition to a careful analysis of federal inspection reports over the past five years.

What we found is that thousands of our oldest, sickest citizens live in nursing homes which more closely resemble 19th century asylums than modern health care facilities. We've allowed bed, board, and abuse to replace the medical and rehabilitative care the law demands.

Each year, 1.5 million Americans spend time in nursing homes at an annual cost of more than $30 billion--about half of which is paid by Medicare and Medicaid. To be eligible for government money, nursing homes must comply with certain "conditions of participation" and undergo periodic inspections to prove they continue to "substantially" meet these conditions.

Committee findings show that almost one-third of the Nation's 8,852 skilled nursing facilities failed to meet at least one basic federal standard to assure the health and safety of residents in 1984. Almost a thousand failed to meet three or more such standards. A substantial number of these homes are chronic offenders, repeatedly defying federal regulations and subjecting thousands of older Americans to inadequate care and squalid conditions.

Our report finds that there has been a dramatic increase in violations of major conditions, including a 75 percent increase in failure to provide physician supervision for patients and a 61 percent increase in failure to provide 24-hour nursing care. Despite the high number of violations, the federal government claims to have decertified only 200 nursing homes in 1985.

This report establishes that our current systems of inspection and enforcement are incapable of assuring that residents actually receive the high quality care the law demands. Congress must act to effectively strengthen these systems and underscore the rights of patients to appropriate, quality care.

JOHN HEINZ
Chairman

Staff Report

United States Senate
Special Committee on Aging
John Heinz, Chairman

NURSING HOME CARE: THE UNFINISHED AGENDA

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NURSING HOME CARE: THE UNFINISHED AGENDA

Staff Report

Special Committee on Aging

United States Senate
John Heinz, Chairman

EXECUTIVE SUMMARY

INTRODUCTION.

This report summarizes the findings of a two year investigation by Committee staff. In the course of this investigation, interviews were conducted with nursing home residents and their families, facility employees and managers, and attorneys and researchers involved with quality assurance in nursing homes. In addition, Committee staff consulted with dozens of State and Federal officials who are responsible for monitoring and enforcing minimum standards for safe and high quality nursing home care.

Committee staff analyzed Federal data depicting the quality of care in the Nation's Federally certified nursing homes, and selected a sample of these facilities for in-depth examination of hard copy inspection reports covering a period of five years. Published research and court filings were reviewed, as well as internal documents from State and Federal governmental agencies.

BACKGROUND:

Federal, State and private spending for nursing care adds up to more than $30 billion per year. Total annual expenditures from private sources is over $15 billion, Medicaid spends more than $14 billion yearly, and Medicare, approximately $650 million. On any given day, 1.5 million patients occupy beds in the nation's 15,000 nursing homes.

Nursing homes seeking Medicare or Medicaid funding must meet certain "Conditions of Participation." These "conditions" represent minimum federal standards for nursing care and physical environment. They include: (1) patients must not be subjected to mental and physical abuse; (2) each patient must remain under the care of a physician who must periodically review the patient's total plan of care and must sign all orders for treatment; (3) the nursing home must provide 24-hour service by licensed nurses; (4) the facility is required to ensure that patients receive adequate nutrition and assistance with feeding where needed; (5) drugs can only be administered by physicians, licensed nurses or trained personnel approved by the state; (6) the nursing home must maintain adequate conditions relating to environment and sanitation.

WHAT ARE THE PROBLEMS IN NURSING HOME CARE?

PROBLEM #1: Tens of thousands of patients in nursing homes still suffer from the poor nutrition, inadequate nursing care, and squalid conditions thought to have been corrected long ago by State and Federal reforms.

- o Nursing home inspection reports reveal that in 1984 over one-third -- 3,036 of the nation's 8,852 certified skilled nursing homes -- failed to fully comply with the most essential health, safety, and quality standards of the Federal government.
- o Nursing home inspection reports reveal that in 1984 about 1,000 (11%) of certified skilled nursing homes were cited for violating three or more critical minimum standards for health and safety,

this despite the fact that nursing homes often have advance notice of an inspection and, thus, are able to prepare ahead of time and conceal or temporarily correct major deficiencies.

PROBLEM #2: Federal inspection reports show that between 600 and 800 certified "skilled nursing" homes in the U.S. chronically fail year after year to meet minimum quality standards.

- The HHS Inspector General has found that 740 SNFs chronically fail to meet key quality care requirements. Using narrower and more conservative standards, Committee staff estimate that 582 facilities are chronically substandard.
- The existance of an alarming number of chronically substandard nursing homes suggests the enforcement system is seriously deficient and ineffective.
- HCFA has failed to use data at its disposal to identify and take action against chronically substandard nursing homes.
- One reason for poor quality is inadequate and poorly targeted reimbursements by Medicaid/Medicare, which forces some nursing home operators to "cut corners" on care.

PROBLEM #3: Finding a nursing home at all, let alone one that offers quality care, is extremely difficult and is a process over which the consumer has little or no control.

- A serious shortage of nursing home beds exists in many communities, the effects of which are felt primarily by Medicaid eligible patients, those who will shortly spend down and become Medicaid eligible, and those with heavier care needs. (The Inspector General of DHHS has recommended that the current excess of hospital beds be used to help alleviate the shortage of nursing home beds nationwide.)
- Greater pressure is placed on patients to find a nursing home because many hospitals have responded to the incentives of the Medicare prospective payment system (PPS) by encouraging earlier discharge.
- Some nursing homes take advantage of the tight bed supply in their communities by illegally extorting financial gratuities from relatives of patients seeking admission to a nursing home.
- The result of the tight bed supply is that substandard homes continue to attract patients for lack of any alternative.

PROBLEM #4: The Department of Health and Human Services (DHHS) has failed in its Congressionally mandated responsibility to ensure that nursing homes receiving Federal funds provide high quality medical and rehabilitative care.

- The 10th Circuit Court of Appeals ruled in a landmark decision in October 1984 that the DHHS enforcement mechanism assures only "paper compliance" with the nursing home quality standards of the Social Security Act.
- DHHS, thus far, has made only limited improvements in the enforcement system, and has failed to propose many necessary reforms.

PROBLEM #5: Existing Federal penalties for use against substandard nursing homes are ineffective in that they limit the number of enforcement actions that can be taken against substandard nursing homes, and expose residents to serious risks from transfers.

- A full array of "intermediate sanctions", or penalties, short of cutting off all Federal reimbursement to the residents of a nursing home, has not yet been enacted by Congress.

- Lacking a Federal receivership authority, whereby enforcement officials appoint a temporary "master" to take over the operation of decertified nursing homes, enforcement officials can only "protect" frail patients from poor care by forcing them to move out of the nursing home.

STAFF RECOMMENDATIONS

Federal Legislation and improved regulation are needed to:

- strengthen the nursing home inspection system;

- mandate improved State response to consumer complaints and requests for inspection and cost reports;

- require the Secretary to report to Congress within 2 years with a recommendation for a case mix reimbursement system for Medicaid nursing home services, including a recommendation for how to meet the needs of patients who will be displaced from nursing homes as case mix reimbursement improves access for a large number of heavy care patients;

- authorize a full array of "intermediate sanction" penalties and a receivership authority, so a measured, incremental enforcement approach can be taken by inspectors, and substandard homes can be improved without relocating all the residents of these facilities;

- elevate the nursing home residents' rights to a Condition of Participation, and strengthen these rights; make providers liable for civil penalties for certain acts of Medicaid discrimination now enforceable only as crimes;

- strengthen the national long term care ombudsman program.

In addition to the above legislative and regulatory changes, the following administrative actions should be undertaken:

- HCFA should expand the hospital swing-bed program, to (1) ease the tight bed supply situation that facilitates illegal discriminatory practices; (2) increase competition in the industry, so quality can be more of a factor in the marketplace.

- HCFA should issue instructions to the State agencies and HCFA regional offices, informing them of their obligation to enforce existing laws, such as (1) penalties for repeat offenders; and (2) prohibitions against Medicaid discrimination.

- HCFA should promptly define what minimum items and services are meant to be provided under the basic daily Medicaid rate in each State, to protect residents' personal funds and to protect providers from unreasonable reimbursement rates.

NURSING HOME CARE: THE UNFINISHED AGENDA

A Staff Report

Special Committee on Aging
United States Senate

John Heinz, Chairman

May 21, 1986

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A Staff Report of the Senate Special Committee on Aging

United States Senate
John Heinz, Chairman

INTRODUCTION.

This report summarizes the findings of a two year investigation by Committee staff. In the course of this investigation, interviews were conducted with nursing home residents and their families, facility employees and managers, and attorneys and researchers involved with quality assurance in nursing homes. In addition, Committee staff consulted with dozens of the State and Federal officials responsible for monitoring and enforcing minimum standards for safe and high quality nursing home care.

Committee staff studied Federal data depicting the quality of care in the Nation's Federally certified nursing homes, and selected a sample of these facilities for in-depth examination of hard copy inspection reports covering a period of five several years. Published research and court filings were reviewed, as well as internal documents from State and Federal governmental agencies.

BACKGROUND.

Federal, State, and private spending for nursing home care adds up to more than $30 billion per year. Total annual expenditures from private sources is over $15 billion, Medicaid spends over $14 billion yearly, and Medicare, approximately $650 million. On any given day, 1.5 million nursing home patients occupy beds in the nation's 15,000 nursing homes.

THE FEDERAL NURSING HOME ENFORCEMENT SYSTEM.

Nursing homes seeking Medicare or Medicaid funding must meet certain "Conditions of Participation." These "conditions" represent minimum Federal standards for nursing care and physical environment.

Roles Of The Federal And State Agencies.

The Health Care Financing Administration (HCFA), Federal funding agency for Medicare and Medicaid, relies upon State agencies and surveyors (inspectors) to enforce the Federal standards through periodic inspections. Federal regulations provide that a nursing home found to "substantially" meet Federal minimum standards can be "certified" to care for Medicare and/or Medicaid beneficiaries.

State survey agencies are required to inspect nursing homes annually to determine whether the facilities are in compliance with as many as 541 standards and requirements pertaining to the level and quality of care, staffing and environment. Examples of the major 20 or 30 standards and requirements critical and essential to maintaining a minimally acceptable level of care are:

1. Patients must not be subjected to mental and physical abuse, nor to (except in emergencies) chemical and physical restraints without a physician's order;

2. Each patient must remain under the care of a physician who must periodically review the patient's total plan of care and must sign all orders for treatment;

3. The nursing home must provide 24-hour service by licensed nurses sufficient to meet the total nursing needs of all patients;

4. The facility is required to ensure that patients receive adequate nutrition and assistance with feeding where needed;

5. Drugs can only be administered by physicians, licensed nurses or trained personnel approved by the state, and cannot be administered without a physician's written order; and

6. The nursing home must maintain adequate conditions relating to environment and sanitation.

The Certification Process.

The federal certification program recognizes two types of nursing homes: (1) Skilled Nursing Facility (SNF) for patients with heavy care needs; and (2) Intermediate Care Facility (ICF) for patients with relatively lighter care needs.

A nursing home may seek certification for either or both Medicare and Medicaid programs. Only SNFs can be reimbursed by Medicare. HCFA reviews State survey agency recommendations, but makes its own determination whether a SNF qualifies for Medicare reimbursement. State survey agencies themselves determine whether a nursing home is qualified to be reimbursed by Medicaid. Medicaid reimburses both SNFs and ICFs.

The State survey agencies, also known as State licensing and certification agencies, are under contract by HCFA to perform two types of annual surveys (inspections), the certification survey and the inspection of care. Both survey and inspection reports are open to public scrutiny.

Federal regulations permit recertification of a nursing home with some deficiencies so it may continue to receive reimbursement from both Medicare and Medicaid. The State, however, must find that the deficiencies "do not jeopardize patient health and safety, nor seriously limit the facility's capacity to give adequate care." A large number of nursing homes are certified under these provisions each year.

When a facility is certified under these rules, the State "agency must maintain a written justification of these findings" that the patients are not in jeopardy. In addition, the nursing home must submit an adequate plan which indicates the deficiencies will be corrected no later than one year after the inspection. If the same deficiency is present during a later inspection, the nursing home cannot be certified for Medicare or Medicaid participation unless it was in compliance "at some time during" the period since the first inspection, "made a good faith effort" to comply with minimum standards, and "was unable to do so for reasons beyond its control".

The only alternative action left to the State under existing Federal regulations is to decertify facilities that fail to meet conditions of participation (for SNFs) and standards (for ICFs). When a nursing home is decertified, all Medicare and Medicaid beneficiaries must be transferred elsewhere.

HCFA performs validation surveys on facilities surveyed by the State agencies to assure that the State process is adequate to guarantee that certified facilities do meet the Federal Conditions of Participation.

The administrative complexity of the overall Federal quality enforcement system for Medicare and Medicaid arises to a large extent from the long-standing view of many Federal officials that Medicaid is a "State" program, whereas Medicare is viewed as a "Federal" program. The Federal government, however, is ultimately accountable for the functioning and efficacy of the Medicaid quality assurance program (please see discussion below regarding the duty of the Secretary of Health and Human Services to assure quality care in nursing homes.)

WHAT ARE THE PROBLEMS IN NURSING HOME CARE?

PROBLEM #1: Tens of thousands of patients in nursing homes still suffer from the poor nutrition, inadequate nursing care, and squalid conditions thought to have been corrected long ago by State and Federal reforms.

Horror stories in nursing homes are thought by many to be rare occurrences, isolated in number and, for the most part, relegated to history. Unfortunately, this is an untrue perception; an alarming number of nursing homes continue to provide grossly inadequate care resulting in humiliation, suffering, and premature death. To establish the depth and severity of persistently dangerous and unhealthful conditions in Federally approved and certified nursing homes, several case histories are appended to this staff report [please see Appendix A].

Nursing home inspection reports reveal that in 1984 over one-third of the nation's certified nursing homes failed to fully comply with the most essential health, safety, and quality standards of the Federal government.

A Federal database containing findings from nursing home inspection reports was analyzed by Committee staff with the assistance of GAO and the Inspector General of HHS. A list of "critical" health and safety standards -- those most directly related to patient well-being in Skilled Nursing Facilities -- was developed by Committee staff in consultation with GAO and the IG, based upon a similar list developed by the Health Care Financing Administration (HCFA) to identify seriously deficient nursing homes. 3,036 skilled nursing homes (34% of a total of 8852) failed to fully comply with these critical standards in 1984. The same database revealed that 987 (11%) certified nursing homes were cited for violating three or more of these critical minimum standards for health and safety during 1984. [Please see Appendices B through E].

The Committee staff estimate is conservative because the Federal database underreports the extent of substandard care being provided in nursing homes on a daily basis: (1) nursing homes know when the inspectors are coming and are able to present to inspectors conditions that are not representative of an average day at the facility; and (2) violations of critical standards identified during several thousand of the more recent inspections have not yet been added by HCFA to the database.

There is evidence to show that some nursing homes are able to predict with great accuracy the impending "unannounced" inspections by State certification teams. The daughter of one resident, who visited her mother in the nursing home 2 or 3 times each day, said

> "They seem to know when the inspections are coming. I was there so often that I could tell what was coming just by the way they were making preparations. For example, the rehabilitation nurse said [they should] put her in a wheelchair for one hour every day with a posey restraint and a back brace. But they wouldn't use the restraint. I told them 'use the restraint, it's in the record'. They checked the record, then put a strap on her! There was no brace. They left her for 3 hours. She was really hurting when they put her in bed. But when [the State] was coming in, all the patients would be up in wheelchairs, and my mom would be up with a posey [restraint] on properly."

Internal memoranda from one chronically substandard nursing home on nursing staff meetings contain numerous references to upcoming inspections:

March 9, 1983 "...the [inspection] report were [sic] an improvement over previous ones. Most felt relieved since everyone had worked so diligently to accomplish the goal....[the nursing home] passed the

	survey....Efforts will be made to avoid a crash effort to prepare for future inspections."
September 14, 1983	"Survey Team is here to check skill care units [sic]. They will return at a future date to survey [another unit]. It was expected that they would survey both areas at this time but there is a difference in cancellation date."
November 2, 1983	"Survey Team...[m]ay visit any day. Our main concern is to maintain certification."
May 2, 1984	"The [State] Survey is expected to be in depth and the special projects hangs on the result of the survey."
October 4, 1984	"State Survey Team is still expected."
February 6, 1986	"Surveys. Two surveys between now and May: [1.] The Post-Survey [and] [2.] The Annual Survey due in May."
February 20, 1985	"Post survey is due in May. This survey will deal with deficiencies found last May. Don't know who will do post survey since they have different teams."

Moreover, according to a February 12, 1986 report by the Inspector General ofDHHS, the inspection report database is incomplete because of poor management by HCFA in the past. In January 1985, IG auditors identified 3,849 nursing home providers in the database for which no inspection findings were recorded for 15 months or more -- in apparent violation of the law which requies annual inspections of nursing homes. Upon further checking, however, the IG learned that 96% of these facilities had actually been inspected, but the results simply had not yet been entered into the database. When the IG auditors doublechecked the completeness of the data base in late October 1985 to see how much progress HCFA has made in reducing the backlog, there were still 3,842 providers with no inspection results for the past 15 months or more.

PROBLEM #2: Federal inspection reports show that almost a thousand certified "skilled nursing" homes in the U.S. chronically fail year after year to meet critical quality standards.

At the request of the Chairman of the Committee, the Inspector General for DHHS analyzed the HCFA database to determine the extent of chronically substandard nursing home care. In a draft report dated November 12, 1985 the IG noted,

> "...we selected [32] of the over 500 standards/elements we felt were most related to patient care. We designed computer programs to identify facilities that failed: [1] a selected condition of participation for two or more consecutive years, [2] three or more selected conditions of participation in any of the last three most recent surveys, [3] any one of the selected conditions of participation two or more times, [4] any one of the selected standards three or more consecutive times. There were [740 skilled nursing homes] that failed one or more of our parameters. We selected a number of these providers in various States to verify the data....Our review showed that the facilities we identified were in fact problem providers who over the course of the past several years showed patterns of noncompliance with important conditions of participation." [Please see Appendix F].

In order to isolate and tabulate the very worst of the repeat offenders, Committee staff analyzed the HCFA database to determine how many nursing homes had violated three critical health and safety standards on three or more inspections out of the most recent four on-site surveys. 582 facilities, or approximately 6.6% of all SNFs, were identified as providing grossly and chronically deficient care to residents. [Please see Appendices B and D]

The existance of an alarming number of chronically substandard nursing homes suggests the enforcement system is seriously deficient and ineffective.

A great deal of attention has been given to the problem of appropriately measuring quality of care in nursing homes [please see Problem #4, below]. The fact that Federal inspection reports themselves can be used to identify almost a thousand certified nursing homes as chronically substandard suggests that the Federal system has failed, not only in measuring poor quality care, but in doing something about it. Subsequent sections of this report address some of the specific barriers to enforcement that prevent the system from assuring quality care.

HCFA has failed to use data at its disposal to identify and take action against chronically substandard nursing homes.

While the problem of chronically substandard nursing homes has long been understood by long term care ombudsmen and State officials, HCFA has done remarkably little to identify these facilities and take action against them.

In 1981 and 1982, HCFA had recognized the value of its inspection report database to analyze the "track records" of individual nursing homes. The agency proposed to identify the best nursing homes in the country, and to subject them to inspections only once every two or three years. The plan was dropped after consumers and the Congress pointed out defects with the plan, in part because the information in the database lagged too far behind actual inspections to be relied upon to identify good nursing homes.

Nonetheless, the HCFA database, even without timely updating, is very useful for identifying repeat offenders in the Federal system: while their most current performance rating is not currently maintained in HCFA's database, their history is a matter of record. Such providers could be targeted for increased scrutiny, as some of the Medicare Peer Review Organizations (PROs) now use much smaller databases to identify providers that should be subjected to intensive review of cases and claims.

Another use for the database could involve examining patterns of State enforcement agency noncompliance with Federal law, such as failure to inspect nursing homes annually. The Inspector General recommended that HCFA use their data for both these purposes.

HCFA, however, has not utilized the database in this way. The Inspector General's report on this subject notes:

> "Contrary to HCFA's conclusion that [the database] is efficiently meeting its objectives, our surveys in the eight HCFA regional offices show that [the database] is not an effective management tool....Results of facility surveys which are required to be performed annually are not input...timely; thus, the system's output is out of date....HCFA regional officials perceive this to be a major deficiency within the system",

and do not use the system to monitor nursing homes or State agencies.

The IG report recommends that the database "be updated and kept current and that it be the basis for HCFA's management decisions regarding surveys and certifications of long-term care facilities. In this regard, we are recommending that a national strategy by developed using [the database] to [h]one in on long term care facilities that have not been surveyed within regulatory time frames or have exhibited aberrant patterns of care."

One reason for poor quality care is inadequate and poorly targeted reimbursements to some facilities by Medicare and Medicaid, which force some nursing home operators to "cut corners" on care.

A nursing home administrator testified on October 24, 1985 before the Committee that Medicare reimbursement to nursing homes does not fully cover the cost of providing care to the new, sicker population being discharged from hospitals under PPS for skilled nursing care. As a result, the administrator could take few very heavy care patients. One reason for this problem may be Medicare's dependence on a facility's cost history in setting reimbursement rate ceilings. A rapid change in patient mix, such as has occurred with the rapid influx of heavier care patients since PPS was implemented, can cause costs to rise faster than reimbursement.

Under the Medicaid program, Congress has given the States a great deal of flexibility to determine reimbursement levels for nursing homes, but clearly required that the reimbursement be sufficient:

> "A State plan for Medical assistance [Medicaid] must ... provide for payment of the [nursing home] ... through the use of rates ... which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable ... quality and safety standards...." [Social Security Act Sec. 1902(a)(13)(A)]

Nursing home industry representatives have provided the Committee with examples of lawsuits filed and won by the industry in States where reimbursement was inadequate to meet the mandate of Congress.

Yet, while the law may provide relief in egregious examples of inadequate Medicaid reimbursement, it seems certain that the present two-level (SNF and ICF) payment scheme fails to fully account for differences in the severity and extent of individual patients' illnesses. A reimbursement scheme more sensitive to differences in patients' needs is needed.

In addition, there is no minimum Federal definition of what services a Medicaid beneficiary in a nursing home can expect to receive from the nursing home. Based upon reports that patients' meager personal funds were being charged for basic services meant to be covered by Medicaid reimbursement, Congress in 1977 required the Secretary to define which nursing home items and services are covered by the Medicaid program. The Medicare/Medicaid Anti-Fraud and Abuse amendments gave the Secretary 90 days after enactment to come up with a minimum list of services covered by Medicaid's nursing home benefit, but this has not been done.

PROBLEM #3: Finding a nursing home that offers quality care is extremely difficult, and is a process over which the consumer has little or no control.

The search for a nursing home bed more often than not is very complicated and a draining experience, emotionally and financially, for both the patient and family. This difficulty is severe enough to have spawned a new industry of professional consultants, "bedhunters," who charge a fee for finding a nursing home bed.

Misinformation, as well as the lack of information, also takes a heavy toll on the inexperienced in the search of a nursing home. For example: a survey by the American Association of Retired Persons (AARP) showed that 79% of its members mistakenly believe that Medicare pays for a large portion of nursing home costs when, in fact, the coverage is very small (only about 2%); seldom are patients and their families aware of the the assistance and information that they may obtain free of charge from federally funded ombudsmen; the nursing home consumer is even less familiar with federal law which prohibits such practices as discrimination against Medicaid-eligible patients; and, virtually all new users of nursing home care are totally unaware state inspection reports on facilities are public documents.

In the course of the investigation, Committee staff learned of examples of relatives being frustrated by additional barriers, including:

- o policies at some State licensing and certification offices to keep inspection reports in only one location in the State, thus forcing interested parties to travel great distances to review it, and
- o inappropriate State agency limitations and delays in response to requests by the public for access to such reports.

Medicare's new prospective payment system (PPS), with its financial incentives for hospitals to discharge patients sooner, has increased time pressures in the search for a nursing home.

A large number (a third or more) of patients are discharged to the nursing home from a hospital with a physician's order or recommendation for nursing home care. The Committee's 1985 hearings into the impact of PPS on quality and access to long term care demonstrated, however, that many hospitals have poor discharge planning and will notify the patient just hours before their impending discharge that they must leave right away. This process leaves little or no time for the hospital discharge planner, patient or family to "shop" for a "good" nursing home. In this case, the "search" is almost invariably reduced to accepting whatever is available, and any consideration of whether the nursing home offers high quality care is lost.

Many communities suffer from a serious shortage of nursing home beds, which is felt most harshly by Medicaid-eligible patients.

There actually are two nursing home markets: one for private pay patients who pay the highest nursing home rates; and a second market for Medicaid-eligible and near-poor patients. Private pay patients, who are charged premium rates by nursing homes, can afford to "shop" for quality. Medicaid patients, who bring the nursing home lower reimbursement rates for care, have less buying power. Consequently, the Medicaid patient often must settle for whatever bed may be available and without quality considerations. Traditional marketplace pressures in most industries serve the valuable function of keeping product quality high. This, however, is not necessarily the case in the Medicaid market of the nursing home industry where the provider can expect to keep beds filled with Medicaid patients even if quality is poor.

A 1983 General Accounting Office study identified the Medicaid-eligible elderly population as suffering disproportionately from a lack of access to nursing home beds. A later report, "Expanding The Swing-Bed Provisions of The Omnibus Reconciliation Act of 1980," by the DHHS Inspector General states:

> "most experts agree that currently there are serious shortages of nursing home beds throughout the country -- estimates range into the hundreds of thousands -- and ... this condition can be expected to worsen."

The IG's 1986 report noted that "Medicare and Medicaid patients are most adversely affected by the bed shortages" and cited reasons for this bed shortage:

- A rapidly growing aged population, particularly the oldest aged -- persons over 85 -- who tend to need nursing home care most often.

- Nursing home construction has not kept pace with increased demand brought about by the aging of the population, in part because of State restrictions on new construction.

Both the 1983 GAO and 1986 IG reports agree that the number of patients "backed up" in hospital beds awaiting discharge to a Skilled Nursing Facility is a valid indicator of access problems. GAO observed this problem was most severe for Medicaid patients with heavy care needs.

The Inspector General of HHS has recommended that the current excess of hospital beds be utilized to help alleviate the shortage of nursing home beds nationwide.

The Inspector General's report recommends that HCFA expand the scope of its "experiment" with swing-beds (unused beds) in hospitals, so that hospitals in urban areas with a shortage of nursing home beds, and an excess of hospital beds, can be paid to care for skilled nursing patients in a hospital. According to the IG, there are approximately 148,500 "excess hospital beds" in the U.S., that could potentially be used to alleviate the current nursing home bed supply shortage.

The IG report argues that if these existing beds were to be used for nursing home care, instead of building 148,500 new nursing home beds, Medicare and Medicaid would realize savings of some $1.9 billion from the "avoided construction of nursing homes". In addition, hospitals would be able to recoup some of their costs of maintaining the empty excess hospital beds, estimated by the IG at some $5.3 billion annually to maintain. This strategy, however, will address only a small portion of the total need for new nursing home beds, estimated by sources cited in the IG report as approximately 600,000 new beds by 1990 -- some 450,000 more than the estimated number of empty hospital beds available for conversion to swing-beds.

It is unlikely, however, that the new beds needed to meet this remaining demand will be built. The Aging Health Policy Center, cited in the IG report, reached this conclusion after reviewing the tight fiscal constraints on Federal and State spending for Medicaid. Nursing home costs now account for as much as 2/3 of some State Medicaid budgets, and have been targeted by States for many years as an area for cutbacks and cost control.

Restrictive State certificate of need policies were cited as a major cause of the slow rate of construction of new nursing home beds, as States seek to restrain rising Medicaid expenditures by constraining the supply of beds. Nine States, according to the IG, have placed a moratorium on new nursing home construction.

In addition, ombudsman advocates in some States have reported that nursing home owners oppose the construction of new beds. Providers already in the market have little incentive to seek expansion of bed supply through new construction for the following reasons:

- o Nursing home corporations have been able to expand by purchasing hundreds of existing facilities each year.
- o As new beds come on the market, occupancy rates would drop -- pinching profitability by raising fixed costs per patient.
- o With reduced occupancy, owners would no longer have as much ability to "pick and choose" the wealthiest patients from the pool of prospective patients. Instead, they would need to accept all candidates to keep occupancy levels as high as possible in the newly competitive market.

The Inspector General's new proposal to expand the hospital swing bed program faces likely opposition from nursing home interests for these reasons.

Some nursing homes take advantage of the tight bed supply in their communities by illegally extorting financial gratuities from relatives of patients seeking admission to a nursing home.

Witnesses at hearings before the Committee in October 1984 and October 1985 testified that many nursing homes engage in a variety of illegal and questionable practices, such as:

- o A former admissions director from a mid-size nursing home chain testified before the Committee on October 1, 1984 that she was ordered by the owners to maintain two waiting lists, one for private pay patients and one for Medicaid eligible patients. She was instructed to admit private pay patients ahead of Medicaid patients, no matter how long the Medicaid patients had been waiting for admission.
- o Refusing to admit, or threatening to evict, a Medicaid eligible patient unless and until s/he agrees to pay a substantial amount of money up front or on a monthly basis. Payments were identified ranging from up front payments of few thousand dollars to tens of thousands of dollars.
- o Requiring that every Medicaid patient have a "guarantor" to pay for items or services provided by the facility to the patient, but not reimbursed under the Medicaid program.
- o When patients have spent down all their money and they must rely upon Medicaid to pay for their care, some facilities move them to less desireable locations in the nursing home.

These practices are widespread, resulting in action by several Attorneys General and State governments (including CA, MD, MI, NY, OH, WA, and WI) to serve notice on the nursing home industry that criminal and or civil prosecution may result.

To date, there has been no concerted action by the Department of Health and Human Services to identify and correct these practices. The HHS Office of Inspector General has referred cases to one or more U.S. Attorneys for criminal prosecution, but reported to the Committee that the U.S. Attorneys have opted not to prosecute any of these cases.

The widespread belief that Medicaid is a State program, to be policed by State officials, has been a significant barrier to achieving concerted Federal action to eliminate forms of Medicaid discrimination prohibited under the Social Security Act.

PROBLEM #4: The Department of Health and Human Services (DHHS) has failed in its Congressionally mandated responsibility to ensure that nursing homes receiving federal funds provide high quality medical and rehabilitative care.

Despite a 1984 Federal Appeals Court order to promulgate regulations for ensuring "high quality medical care" in nursing homes, the Department has instituted only limited reform and improvement in the enforcement system.

The landmark decision, issued by the 10th Circuit Court of Appeals, grew out of a suit filed by a group of Colorado nursing home patients in 1975. The patients had contended that the enforcement system that had been developed by the Secretary of DHHS was "facility-oriented," not "patient oriented" and thereby failed to comply with federal law.

In its October 1984 opinion, the Federal Appeals Court concluded:

"failure to promulgate regulations that allow the Secretary to remain informed, on a continuing basis, as to whether [nursing homes] receiving federal money are meeting the requirements of the [law, including providing high quality patient care], is an abdication of the Secretary's duty."

The DHHS responded to the Court's order by promulgating regulations for a new type of nursing home inspection, first known as the "Patient Care and Services" survey and later renamed the "Long-Term Care Survey Process (LTCSP)". The new survey process has undergone pilot trial in a handful of facilities in each of 47 States and, after several delays, is scheduled to be fully implemented in July 1986.

The LTCSP places far more emphasis on quality of care andpatient outcomes than does the existing survey and compliance system. Nonetheless, LTCSP has drawn substantial criticism for lacking in a number of areas. For example, the recently published report, "Improving the Quality of Care in Nursing Homes," by the Institute of Medicine (IOM) lists five "major problems" with the new survey system. They include: (1) "the conditions and standards *** remain oriented toward facility and capability and do not include quality-of-life factors"; (2) LTCSP lacks "a formal protocol for sampling of residents for detailed reviews of caregiving"; (3) the new process "still relies on unguided surveyor judgement to make the important decisions of whether care problems demonstrated by a facility constitute deficiencies"; (4) LTCSP "procedures do not require the facilities to maintain standard resident assessment data"; and (5) the new system "does not integrate the [LTCSP] survey with the inspection-of-care (IOC) [inspection]."

The director of Washington State's Bureau of Nursing Home Affairs, Conrad Thompson, contends that LTCSP has "fundamental flaws." According to Thompson, in order for the new system to be "a valid and reliable process," it needs: "[1] inclusion of a standardized patient assessment process; [2] development of a statistically valid sampling methodology; [3] proper training for [State] surveyors; and [4] stronger focus on resident rights, the physical plant environment and administrative responsibility."

Rehabilitation Care Consultants, Inc., a private firm hired by HCFA last year to analyze and evaluate pilot trials of the new survey process, issued its final report in November 1985. Among the firm's findings was that there appeared to be "a wide variance in how individual states decided upon what to cite as deficiencies, what not to cite, and what to label as recommendations." The report stated:

> "It became clear that all states do not agree as to whether surveyors are to act as consultants or enforcers. For example, several states cited deficiencies that in other states were presented to the facilities as recommendations."

This very same problem of variance among states on what to cite and what not to cite as being deficient has plagued the existing survey process.

On April 9, 1986 twenty national organizations, lead by the National Citizens' Coalition for Nursing Home Reform (NCCNHR) and including organizations representing the nursing home industry, urged the Department to establish a reasonable phase-in period for implementation, to improve initial and follow-up training, revise guidelines for inspectors, and allow States to establish innovative inspection procedures under waiver.

Critics of the new LTCSP survey system all seem to agree that HCFA must place far more emphasis on oversight of state survey agencies and especially on the training of the surveyors themselves. To date, HCFA has taken the position that the new survey process should be implemented first, and changed later to meet these concerns.

Preliminary findings of a study conducted for the Committee by the General Accounting Office provide additional evidence to show that enforcement is inadequate. In a statement prepared for the Committee's hearing record, GAO was critical of HCFA for having made only "limited use" of the "repeat deficiency" regulation.

This regulation requires that before a State can recertify for Medicare/Medicaid reimbursement a "repeat offender" nursing home (i.e. one that has violated a health and safety standard twice or more), the State must first determine that the facility did comply with the standard at some point during the past year, made a good faith effort to come into compliance prior to failing the same standard for a second time, and that reasons for the second failure were beyond the nursing home's control.

GAO reviewed the certifications of 10 "repeat offender" nursing homes and found that had not undergone the review required by the repeat deficiency regulation. The GAO report to the Committee states:

> "Our work to date has provided indications of uncertainty and lack of agreement among state and HCFA regional personnel in applying the repeat deficiency regulations *** HCFA regional office officials told us that repeat deficiency regulations generally are not being applied by states or by HCFA *** [I]t appears that HCFA needs to more clearly enunciate agency policy regarding repeat deficiencies and provide additional guidance and assistance to the states and HCFA regions in interpreting and applying the repeat deficiency regulations."

PROBLEM #5: Existing Federal penalties for use against substandard nursing homes are ineffective in that they limit the number of enforcement actions that can be taken against substandard nursing homes, and expose residents to serious risks from transfers.

Decertification is the only Federal penalty presently available to HCFA and the State certification agencies for use against a nursing home that fails to meet Federal health and safety standards. Decertification is analogous to shutting the nursing home down, in most cases where it is invoked, because facilities typically cannot afford to operate without the reimbursement from Federal programs. This is because, on any given day, about two-thirds of all nursing home patients are Federal beneficiaries, accounting for about half of the average facility's revenue.

Decertification is rarely used as a penalty. The following table depicts the number of involuntary terminations for violations of health and safety standards, by year.

INVOLUNTARY TERMINATIONS OF NURSING HOME CERTIFICATION

	1980	1981	1982	1983	1984	1985*
Total Number Terminations	90	48	41	27	40	24
Total Number SNF Terminations	45	26	10	7	11	3

***Note**: Data for 1985 are incomplete due to slow input of data by States and HCFA Regional Offices.

The Institute of Medicine of the National Academy of Sciences observed in its recent report on nursing home care "[b]ecause of the undesirability of closing facilities and relocating residents, states rarely terminate" providers from Federal programs. A broad consensus of

State regulators and long term care advocates agree that relocating residents of nursing homes is a remedy that causes problems of its own.

One nursing home patient interviewed by Committee staff was relocated from the Pennsylvania nursing home he lived in for years. He returned from the local senior center one day to be informed by an aide that she had "bad news" -- he would have to move out. Facility employees packed his belongings that night, and moved him out the next day. In the chaotic transition from the closing nursing home to another facility across town in an unfamiliar neighborhood, the ambulance drivers became lost, and the patient had to direct them back to their starting point. In addition, this patient lost $1800 in personal funds, along with other residents' money held by the facility, because the nursing home had closed down without paying back the residents' monies. Because he is a Medicaid eligible patient, he had no choice in the nursing home he was moved to. According to local sources, his new home is "one of the worst in town" and has been in trouble with the State.

Congress recognized that decertification is a crude tool to use on substandard nursing homes, when legislation was adopted in 1980 creating the "Alternative to Decertification" authority. The new law authorized the Secretary and the State certification agencies to impose a moratorium on future admissions of Federal beneficiaries at substandard nursing homes. By preventing new admissions, the enforcement officials can protect patients not now in the facility from being admitted into substandard conditions, while lessening the burden of new admissions on the nursing home. In addition, the moratorium can amount to a financial penalty if the facility does not improve swiftly.

The Federal authority is meant to be used on facilities that are substandard, but which are not so poor as to require decertification. For facilities that are to be decertified, the moratorium must be invoked immediately. Several States have a similar authority now, according to the Institute of Medicine's recent poll of State certification agencies. In one State, however, the authority is only used when license revocation is proposed, and so cannot be viewed as an "intermediate" penalty.

The Office of General Counsel of DHHS ruled after Congress created the moratorium on admissions authority that regulations would be needed to implement the new law. In 1983, constituents made the Committee Chairman aware of persistently substandard conditions in a Pennsylvania nursing home, where the moratorium on admissions penalty could usefully be imposed. A series of letters and meetings followed between December 1983 and the Summer of 1985, wherein Committee staff expressed to the Department the need for prompt issuance of the regulation and made suggestions for improvements. In November 1985, at the Chairman's request, the Inspector General recommended to HCFA that similar changes to those suggested by the Committee be made in the proposed moratorium on admissions authority. Issuance of the revised the regulation is reportedly a high priority of the new Secretary of HHS.

State licensing and certification officials support the development of a full range of Federal penalties for use against providers that violate minimum health and safety standards. Although many State legislatures have enacted a variety of penalties or "intermediate sanctions", few States have the flexibility they need to respond appropriately to substandard care. In Washington State, according to Conrad Thompson, chief of licensing and certification, several such authorities have been enacted. Yet he reports the State is unable to respond fully to chronically substandard nursing homes without a receivership authority. By appointing a receiver or "master" to operate a nursing home that is being decertified, enforcement officials can begin immediately to improve care for the residents without the chaos and disruption engendered by relocation of residents. The temporary operator appointed by the State leaves when a satisfactory permanent owner or manager can be approved by the State.

By making decertification a more practical sanction, receivership should enable States to decertify facilities. Some version of this authority exists in many States, including Arizona, California, Colorado, Connecticut, Florida, Illinois, Iowa, Kansas, Maryland, Minnesota, Missouri, New Jersey, New York, Oklahoma, Pennsylvania, and Wisconsin.

Sandra Casper, R.N., a consultant who has worked with nursing homes and enforcement officials in some 30 States, reported to the Committee that States vary tremendously in their commitment to imposing penalties on substandard nursing homes. The Institute of Medicine report also refers to sharp differences of opinion between States with a consultation orientation, as opposed to an enforcement approach. As long as State officials are reluctant to impose penalties on nursing homes, the enactment of a full array of penalty authorities will be insufficient in and of itself to bring about improved care in substandard nursing homes.

STAFF RECOMMENDATIONS

1. Federal legislation and improved regulation are needed to:

   o strengthen the nursing home inspection system;

   o mandate improved State response to consumer complaints and requests for inspection and cost reports;

   o require the Secretary to report to Congress within 2 years with a recommendation for a reimbursement system for Medicaid nursing home services that is based on patient mix according to severity of illness of the patients, including a recommendation for how to meet the needs of patients who will be displaced from nursing homes if reimbursement reform succeeds in improving access for a large number of heavy care patients;

   o authorize a full array of "intermediate sanction" penalties and a receivership authority, so a measured, incremental enforcement approach can be taken by inspectors, and substandard homes can be improved without relocating all the residents of these facilities;

   o elevate the nursing home residents' rights to a Condition of Participation, and strengthen these rights; make providers liable for civil penalties for certain acts of Medicaid discrimination now enforceable only as crimes;

   o strengthen the national Long Term Care Ombudsman program. Congress should mandate reporting by Ombudsman programs, and include a requirement to oversee and comment upon the adequacy of State licensing and certification offices.

2. In addition to the above legislative and regulatory changes, the following administrative actions should be undertaken:

   o HCFA should expand the hospital swing-bed program, to (1) ease the tight bed supply situation that facilitates illegal discriminatory practices; (2) increase competition in the industry, so quality can be more of a factor in the marketplace.

   o HCFA should issue instructions to the State agencies and HCFA regional offices, informing them of their obligation to enforce existing laws, such as (1) penalties for repeat offenders; and (2) prohibitions against Medicaid discrimination.

   o HCFA should promptly define what minimum items and services are meant to be provided for the basic Medicaid reimbursement rate in each State, to protect residents from loss of personal funds and to protect providers from unreasonably low reimbursement rates.

APPENDIX A:

CASE STUDIES OF CHRONICALLY SUBSTANDARD NURSING HOMES

CASE STUDY #1

LOCATION: Washington, D.C.
TYPE OF FACILITY: Skilled Nursing Facility
CURRENT STATUS: FULLY CERTIFIED

SUMMARY OF MAJOR VIOLATIONS

DEFICIENT ON REQUIREMENTS FOR MEDICAL STAFF

February 1983:
o Medical Director failed to review all incident reports involving patients
o Overall lack of proper staff training and supervision

April 1983: Missing health records for new employees

December 1983:
o Facility does not follow personnel procedures for reviews; requiring medical exams, x-rays and TB screens
o Medical Director fails to assure health, safety and well being of patients

July 1984:
o Administrator not licensed in District; no evidence that podiatrist and one nurse were licensed

June 1985: No evidence that 2 physical therapists licensed

INADEQUATE PATIENT SUPERVISION BY PHYSICIAN

April 1982:
o All patients not seen by physician at least every 30 days

January 1983: 25% records reviewed had no current physical

February 1983:
o All patients not seen by physicians as required within 48 hours of admission

December 1983:
o Physician failed to certify death for 7 hours after patient expired
o Physicians failing to sign verbal prescription orders; signing other physicans' orders

July 1984:
o 30-day reviews of total care programs by physicians don't include revised orders for activities, restraint and physical therapy; progress notes not written and signed on each visit by physician

December 1984:
o Progress notes not written and signed on each visit by physician

UNACCEPTABLE NURSING CARE

April 1982:
o Facility does not provide 24-hour nursing services sufficient to meet total needs of patients (evidenced by high number injuries from falls; 25 of 32 patients have decubitus ulcers)
o Residents in restraints not exercised to prevent contractures

January 1983:
o Patients not getting adequate 24-hour care
o Nursing care plans not complete on all residents
o Nursing personnel not taking precautions to prevent infections

February 1983:
- Nursing care plans not complete on all residents
- Patients in restraints not released as required for exercise
- Patients bathed and toiled without attention to privacy
- Incontinent patients not changed in timely manner
- Patients dressed in ill fitting or mismatched shoes, clothes; some without underwear

December 1983:
- Nursing care plans not complete on all residents
- Patients restrained without physican's order
- Nurses not recording body weights; intake and outputs; turning patients
- No evidence of routine oral hygiene being done for patients

July 1984:
- No record of turning bedridden patients and of checking, releasing, exercising patients placed in restraints;
- Physically weak patients observed in geri-chairs from breakfast until 4 PM;
- Patients not well groomed--some without underwear, shoes or socks;
- Physicians' orders for treatment not carried out.

December 1984:
- Improper preparation, record of drug administration

June 1985: Administering drugs without written prescription

ABSENCE OF REHABILITATIVE NURSING CARE

February 1983: No record of rehabilitative nursing program

December 1983: Insufficient rehabilitative program

July 1984:
- Facility lacks active program of rehabilitative nursing care (designed to help patients achieve optimal level self-care and independence)

POOR DIETARY SERVICES AND SUPERVISION

January 1983:
- Food not served at proper temperature
- Kitchen equipment not maintained in sanitary manner

February 1983:
- Insufficient supervision of staff
- Therapeutic diets improperly served
- Food stored beneath exposed water pipes; milk stored on floor
- Ceiling tiles dirty and water stained; missing wall tiles; dirty tiles throughout kitchen
- Food residue remained on plates after washing
- Fermenting garbage and water in trash compactor

December 1983:
o Staff inadquately trained to prepare therapeutic diets as ordered
o Serving utensils unsanitary
o Food spillage on food carts

February 1984:
o Floor throughout food service area dirty, coated with greasy film
o Exteriors of kitchen equipment solid with spillage
o Wall tiles streaked with spillage or coatd with greasy film
o Food stored under condensate dripping from cold water pipes
o Therapeutic diets not prepared as ordered

July 1984:
o Therapeutic menus not served as ordered (Example: diabetic diet tray had two packages of sugar)
o Intake records not maintained on patients on forced fluid diets
o Patients without teeth or dentures served regular meals (steak, apples, other "hard" food)
o Inadequately trained staff; poorly supervised food preparation
o Unsanitary conditions in dishwashing area

December 1984: Substandard food service (no temperature control)

June 1985:
o Inadequate staffing (both numbers and training)
o Therapeutic meals not served as ordered
o Substandard food service (meals late, no temperature control)
o Unsanitary conditions throughout food preparation and dishwashing areas

BADLY MONITORED ADMINISTRATION OF DRUGS

April 1982:
o Medications not administered according to physician's orders; some administered without prescription
o Physicians don't sign verbal orders; physicians write incomplete prescriptions (omit quantity and time)
o Medications stored without expiration dates and manufacturer's name

January 1983:
o Physicians don't sign verbal orders; write incomplete prescriptions

February 1983:
o Drugs carts left unlocked and unattended; drug cabinents unlocked

December 1983:
o Medications not given according to physicans orders
o Physicians don't sign verbal orders; write incomplete prescriptions; sign other physicians orders

February 1984:
- o Drugs stored without proper labelling
- o Numerous over-the-counter pharmaceuticals, topicals and other items found in patients' rooms with no instructions from physician for self-administration

July 1984:
- o Lack written prescriptions for many drugs administered
- o Medications and biologicals kept in unlabeled, unsanitary containers

December 1984:
- o No documentation that pharmacist reviewed drug program of patients at least monthly
- o Inadequate monitoring of entire drug program to ensure accuracy and adequacy (Note: some patients not getting prescribed medications)

June 1985:
- o Lack written prescriptions for many drugs administered
- o Inadequate monitoring of entire drug program to assure adequacy and accuracy (Note: physicians writing incomplete medication orders)

UNSANITARY, DETERIORATING PHYSICAL ENVIRONMENT

April 1982:
- o Linens not properly sterilized
- o Wheelchairs, gerichairs, furniture, bedside rails not clean, sanitary
- o Insufficient staff to assure effective facility maintenance
- o Roaches throughout premises

January 1983:
- o Linens not properly sanitized
- o Roaches throughout premises
- o No records of maintenance
- o Interior in bad repair--missing tiles; soiled rooms; water and air seepage around windows; floor drains clogged with debris

February 1983:
- o Dirty floors, walls, tiles and other surfaces
- o Dirty laundry room
- o Ceiling missing in tub room; metal studs exposed in shower room
- o Discarded oxygen and suction tubing, other used supplies, left in patients' rooms
- o Scale and accumulated materials on bedpans
- o Patients' soiled clothing on furniture, floors along with clean items
- o Roaches throughout premises; rat poison in pantry

December 1983:
- o Residents' rooms had srong urine or fecal odor
- o Holes in walls in residents' rooms

o Leaking faucets; damaged, torn floor and wall coverings
o Water temperature not maintained
o Rotting and damaged cabinets, furniture
o Feces and urine on commodes;
o Dirty linen mixed with clean
o Dirty syringes used for tube feedings; oral and rectal thermometers stored together
o Inadequate staff in laundry and maintenance
o Basic infection control procedures not adequate

February 1984:
o Wall covering stained, torn; floor patched with plastic tape; molding peeling from room walls
o Holes in walls in residents' rooms
o Roaches throughout premises
o Unsanitary bedpans stored with residents' clean clothing
o Fecal odor in rooms and closets
o Carts for collecting and delivering linen grossly soiled

July 1984:
o No documentation of maintenance on equipment
o Dirty floors, furnishings, light fixtures

December 1984:
o Dirty floors, furnishings, light fixtures
o Damaged/missing floor coverings, wall and ceiling tiles, baseboards
o Soiled and clean clothing stored together in plastic bags on floor
o Damaged windows; damaged bathroom hardware

June 1985:
o Inadequate lighting and ventilation, lose electrical fixture
o Sinks separating from foundation, window hardware coming lose
o Wall and floor coverings damaged/missing
o Bedrails not secured; check of drawers not stabalized
o Suction machines not cleaned after each use

CASE STUDY #2

LOCATION: San Francisco, California area
TYPE OF FACILITY: Skilled Nursing Facility (SNF)
CURRENT STATUS OF FACILITY: FULLY CERTIFIED

SUMMARY OF MAJOR VIOLATIONS

DEFICIENT ON REQUIREMENTS FOR MEDICAL STAFF

September 1981:
- o Social Service director not qualified
- o 11 of 12 new employees without physical and TB screening

October 1982:
- o Administrator fails to enforce rules and regulations to protect health and safety of patients
- o 75% employees without current physical and TB screening

December (Revisit): Standard still not met

July 1984:
- o Administrator failed to do required evaluations of adequacy of health professional services

March 1985:
- o Administrator fails to rules and regulations basic to health and safety of patients
- o Cook, laundry supervisor not qualified for jobs
- o Inadequate number of personnel employed
- o Nurse assistants lack proper in-service education

INADEQUATE PATIENT SUPERVISION BY PHYSICIAN

October 1982:
- o Patients not seen by physician at least every 30 days
- o Progress/orders notes inadequate to give picture of patients conditions and needs

July 1984:
- o Patients not seen by physican at least every 30 days
- o Physican failed to respond to changes in patients conditions with new programs for care
- o Progress/orders notes inadequate to give picture of patients conditions and needs

March 1985:
- o Patients not seen by physician at least every 30 days
- o Emergency phone numbers for physicians not posted

UNACCEPTABLE NURSING CARE

September 1981:
- o Designated charge nurse not qualified
- o No long term goals for nursing care plans
- o Not sufficient number of nurses for proper patient care

October 1982:
- o 24-hour nursing care not provided
- o Patients not well groomed--lax oral care; scaly, dry skin
- o Patients left restrained for hours without position change or toileting
- o Plans for patient care not developed and adequate records of care kept
- o Physicians not notified promptly of laboratory results

December 1982 (Revisit):
- o Still no procedure for notifying physician when decubiti (bedsores) first appear
- o Still lack plans for patient care and adequate records

July 1984:
- o Failure to monitor patients with eye and skin conditions
- o Failure to notify kitchen of new diet requirements and to serve therapeutic diets correctly
- o No nurse supervisor on each shift
- o Patients left unattended in restraints for long periods
- o Patients records lack data necessary to give clear picture of progress/problems

October 1984 (Complaint):
- o Patient transferred to acute hospital without notification of family until two days later
- o Medication not administered as prescribed by doctor
- o No record of patient's fall and resulting problems

March 1985:
- o Nurses failed to notify physician immediately regarding sudden or marked adverse change in patients' conditions (Examples: patients with staph infections; patients with first occurrance of decubitus ulers; patient with pneumonia; patient given wrong medication which was life threatening)
- o Daily rounds did not include visits with all patients
- o No nurse supervisor on each shift
- o 24-hour nursing service not provided (catheters not changed; contaminated pads and needles not removed; infection control procedures not implemented; vital signs not taken)
- o Patients not well groomed--feces and urine on skin; needed shaves; teeth not cleaned; offensive odors
- o Vital signs/test not taken regularly and recorded
- o Health records show no evidence of continuing assessment of patients' needs by all concerned professionals.

September 1985 (Investigation):
- o Urinary tract infection untreated, with patient subsequently admitted to an acute care facility

- Decubitus ulcer (bedsore) documented as healed, then identified in advanced stage 12 days later
- Patient's nutritional needs not asessed for four-month period during which four decubitus ulcers appeared
- Decubitus ulcer on patient not noted on care plan for one week

ABSENCE OF REHABILITATIVE NURSING CARE

September 1981:
- Rehabilitative nursing care not being carried through

October 1982:
- Facility lacks active program of rehabilitative nursing care, designed to help patients achieve optimal level of self-care and independence

December (Revisit): Rehabilitative program still not initiated

March 1985:
- Facility lacks active program of rehabilitative nursing care, designed to help patients achieve optimal level of self-care and independence (patients not kept active and out of bed;
- incontinent patients not given bowel/bladder management program;
- restraints and postural supports applied without supervision, improperly without concern for circulation)

POOR DIETARY SERVICES AND SUPERVISION

September 1981:
- Food not stored, prepared or served under sanitary conditions
- Kitchen equipment not in good working order

October 1982:
- Diet manual not approved by dietitian
- Inadequately trained staff
- Special diet trays not controlled (salt on sodium restricted trays).

December (Revisit):
- Special diet trays still not prepared and delivered as ordered

July 1984:
- Food not served at proper temperature
- Special diet trays not controlled (salt on sodium restricted trays)

March 1985:
- Meals not adequate for nutritional needs of patients
- Patients not assured necessary fluids for hydration
- Patients needing assistance in eating not getting it
- Inadequately trained staff
- Facility failed to cook enough food, delivered food late, served without appropriate eating utensils.

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BADLY MONITORED ADMINISTRATION OF DRUGS

September 1981:
o Drugs and treatments not given as prescribed
o Drugs administered by unlicensed person
o Employees unable to identify all patients before giving drugs.

February 1982: Sufficient medical supplies not available

October 1982:
o Medications not administered as prescribed
o Dose/time drug given not always recorded
o Lack written prescriptions for many verbal orders
o Inadequate monitoring of controlled drugs

December (Revisit):
o Dose/time drug given still not consistently recorded
o Still no procedures to assure medications administered as prescribed

July 1984:
o Drugs stored at wrong temperatures
o Inadequate supplies of emergency medications
o Drugs given after stop orders issued

March 1985:
o Medications not administered as prescribed
o Prescription medications administered without order of person lawfully authorized to prescribe
o Drugs stored without labeling; contaminated or deteriorated drugs were available for use; drugs were accessible to other than authorized personnel
o Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomformt not available and administered within 4 hours of time ordered

UNSANITARY, DETERIORATING PHYSICAL ENVIRONMENT

September 1981:
o No records of equipment maintenance
o Furniture, windows, shower rooms need cleaning, repair
o Insufficient linen (torn blankets for face cloths; sheets used as bath towels)

October 1982:
o Facility overall not clean, sanitary and in good condition
o Ceilings and walls need repair and paint
o All furniture in patients' rooms need cleaning, repair
o Soiled egg crates found in patients' closets, clothing piled on tables
o Water heaters malfunction
o Used urinals and bedpans left in rooms; water fountains soiled; no soap, toilet paper and towels missing from some bathrooms
o No supervision of maintenance staff

o Inadequate provisions for cleaning, disinfecting or contaminated areas

December 1982 (Revisit):
o Ceilings and walls need repair, cleaning and paint
o Furniture needs cleaning and repair
o Draperies need repair and proper hanging
o Inadequate provisions for cleaning, disinfecting of contaminated areas

July 1984:
o Walls soiled; floor tiles chipped; paint in corridor incomplete
o Building eaves dented, exterior paint scarred and patched

March 1985:
o No documentation to show equipment regularly maintained
o Dirty floors and walls; sticky handrails; hole in wall; soiled drapes and furniture; bathroom floors badly stained with urine odor;
o Hot water temperature controls not working
o Inadequate provisions for cleaning, disinfecting of contaminated areas; no provisions for isolating patients with infectious diseases

CASE STUDY #3

LOCATION: Georgia
TYPE OF FACILITY: Skilled Nursing Facility

SUMMARY OF MAJOR VIOLATIONS

INADEQUATE PATIENT SUPERVISION BY PHYSICIAN

April 1984:
o Restraints were placed on patients without physician's orders.
o Physician's signatures on verbal orders provided to nurses, had not been countersigned within 48 hours.

September 1984:
o Problems as stated in the patient care plans are not specific, so that, the actual patient problem or need is not always identified.

UNACCEPTABLE NURSING CARE

April 1983:
o Inadequate nursing services to meet patient requirements, i.e., tests were not performed as ordered by the physician, poor maintenance of patient medical records, privacy curtains were not used by nursing personnel to ensure privacy for the patient, bowel and bladder retraining programs were not adequately documented, failure to document the administration of drugs, and linens were not properly handled.
o Inadequate levels of nursing personnel were available to feed patients during the meal service.

July 1983:
o Rehabilitative nursing is not an integral part of nursing as demonstrated by the improper use of restraints; absence of nursing personnel to assist patients while dining and lack of needed silverware to help patients reach an optimal level of self-care in feeding.
o Nursing personnel are not aware of the nutritional needs of the patients.
o Drugs are not being administered in accordance with physician's orders.
o Twenty-eight doses of a common drug were administered in error before being stopped.
o Poor monitoring of patient care; one patient requiring close monitoring, had not had his vital signs taken for four days.

April 1984:
o Inadequate nurse supervision by the charge nurse, has resulted in restraints on patients, not being appropriately checked and released.

o Over 90 incontinent patients have not been assessed to determine if they would benefit from a bowel and bladder re-training program.

July 1984:
o In accordance with the facilities own procedures, patients are not receiving baths as required.

April 1985:
o Significant changes in patient health care, such as receiving a major head injury, was not reported to the physician, nor the patient's family.
o Pertinent information concerning the patient's recovery, was not documented by the charge nurse, into the medical record.
o Documentation of patient injuries and the examination by the physician assistant, were not appropriately recorded.
o Patient care plans are not being reviewed, evaluated and updated as the status of the patient changes.
o Inadequate nursing personnel are available to assist patients during feeding.
o Failure of the charge nurses to delegate responsibilities to other nursing personnel, has resulted in vital information concerning patient care, not being provided to assistants working with the patient (i.e., seizure potential, diabetic, blindness, use no soap, (keep) feet elevated at all times, etc.).

October 1985:
o Treatment of patients is rendered without consideration, respect and full recognition of their dignity and individuality, i.e., lack of privacy, male patients unshaven, patients in bed without clothing and exposed, patient's diaper being changed without privacy curtains being used or the door closed, patients sitting and lying in their own feces and urine.
o Insufficient number of qualified personnel to meet total nursing needs and to ensure that patients receive treatments and medications as prescribed.

POOR DIETARY SERVICES AND SUPERVISION

July 1983:
o According to residents, meals are often cold when they receive their trays.
o Non-hygenic food handling techniques are used by the facility staff.
o Infestation of flies in the dining area, which were alighting on patient's food.

April 1984:
o Assistance is not provided to patients needing it during meal services.
o Therapeutic and restricted diet menus were not prepared as instructed.
o Dietetic services staff lacked proper training.

September 1984:

o Tuberculosis testing of dietary employees had not been performed, as required.

January 1985:
o Baths are not provided to patients as frequently, as needed. Also partial baths are not given in between the twice a week complete baths.
o Call lights are not answered promptly, as reported in 5 out of 10 patient interviews.

BADLY MONITORED ADMINISTRATION OF DRUGS

April 1983:
o Inadequate documenation on the administration of drugs to patients.

July 1983:
o Failure to administer drugs inaccordance with physician's instructions.

April 1984:
o Improper documentation on 75% of the medication administration records, indicating that patients received too few or too many doses.

October 1985:
o There were omissions on the patient's medication administration record where the nurse failed to appropriately document the administration of medications.

UNSANITARY, DETERIORATING ENVIRONMENT

April 1983:
o Unsanitary procedures are followed in the handling of linens.

July 1983:
o Insufficient supply of linen.
o Clean towels had the odor of feces.
oInfestation of roaches and flies.

July 1984:
o Inadequate supplies of linen, existed throughout the facility.

January 1985:
o Additional towels and face cloths are needed to meet the needs of patients.
o Insufficent janitorial services, i.e., floors and bathrooms needed cleaning, urine odors permeated the area, and bed side commodes were not being cleaned and emptied after use.

April 1985:
o Dirty and clean linens were not keep separated.

October 1985:

o Each patient did not have an individual towel and face cloth.
o Soiled linens were left lying around and linens were not handled in such a manner as to prevent infection.
o Large infestation of roaches exist at the facility.
o Unsanitary facilities, bath rooms not properly cleaned, severe build up of dirt, grime and wax along the walls and dried feces on toilet stools. General shower and bath facilities were used to store unused chairs, boxes, coat hangers and unserviceable material.

CASE STUDY #4

LOCATION: WASHINGTON, D.C.
TYPE OF FACILITY: SKILLED NURSING FACILITY

SUMMARY OF MAJOR VIOLATIONS

UNACCEPTABLE NURSING CARE

MARCH 1983:
o Lack of conformance with written procedures, in reporting significant changes in patient health status to relatives.

MAY 1984:
o Failure to promptly notify the family of patient's death; family informed of death three days later.

DEFICIENT CONCERN FOR PATIENT WELFARE

MARCH 1983:
o Violations of residents rights and examples of mistreatments observed: 1) facility fails to provide diversional activities commensurate with the residents interest, abilities and goals in order to enhance feelings of involvement and self-respect 2) insufficient access to the handicapped telephone for wheelchair bound patients 3) privacy curtains missing on toilet stalls.
o Financial accounts are maintained for residents without required written authorizations.

MAY 1985:
o Failure to provide patients with regular financial accounting, of transactions made in their behalf.

JANUARY 1986:
o Insufficent documentation to evidence that patients and/or their guardians are provided a financial accounting for patient funds.

PHARMACEUTICAL SERVICES

APRIL 1982:
o Failure of the consultant pharmacist to provide appropriate procedures for dispensing and administration of drugs and biologicals.
o Medications were improperly labeled.
o Lack of existence of the Pharmaceutical Services Committee, as required by Federal regulations.

MARCH 1983:
o Lack of compliance with Federal regulations regarding membership on the Pharmaceutical Services Committee.

MAY 1984:
o Inadequate monitoring of the entire drug program:

MAY 1985:

o Pharmaceutical Services Committee did not monitor services to assure accuracy and adequacy: (a) physicians failed to date and countersign telephone orders, (b) failure to administer medications to patients, (c) medications administered after the scheduled treatment time.

APPENDIX B

RESULTS OF COMMITTEE STAFF ANALYSIS OF NURSING HOME INSPECTION REPORTS

STATE	SNFs with less than 3 DEFICIENCIES 1984		SNFs with 3 or more DEFICIENCIES 1984		TOTAL SNFs DEFICIENT 1984*		SNFs CHRONICALLY DEFICIENT 1980-85**	
(Total SNFs)	#	(%)	#	(%)	#	(%)	#	(%)
ALABAMA (193)	72	(37%)	65	(34%)	137	(71%)	33	(17%)
ALASKA (9)	2	(22%)	2	(22%)	4	(44%)	0	
ARIZONA (49)	12	(25%)	2	(4%)	14	(28%)	0	
ARKANSAS (132)	44	(33%)	37	(28%)	81	(61%)	35	(26%)
CALIFORNIA (1,165)	472	(40%)	239	(20%)	711	(61%)	141	(12%)
COLORADO (156)	36	(23%)	15	(10%)	51	(83%)	12	(9%)
CONNECTICUT (209)	88	(42%)	46	(22%)	134	(64%)	34	(16%)
DELAWARE (25)	7	(28%)	1	(4%)	8	(32%)	0	
WASHINGTON, DC (8)	3	(37%)	1	(12%)	4	(50%)	0	
FLORIDA (409)	61	(15%)	20	(5%)	81	(20%)	6	(1%)
GEORGIA (261)	71	(27%)	42	(16%)	113	(43%)	29	(11%)
HAWAII (27)	4	(15%)	0		4	(15%)	0	
IDAHO (59)	18	(30%)	1	(2%)	19	(32%)	1	(2%)
ILLINOIS (466)	84	(18%)	3	(1%)	87	(19%)	2	(1%)

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984 #	(%)	SNFs with 3 or more DEFICIENCIES 1984 #	(%)	TOTAL SNFs DEFICIENT 1984* #	(%)	SNFs CHRONICALLY DEFICIENT 1980-85** #	(%)
INDIANA (197)	23	(12%)	11	(6%)	34	(17%)	31	(16%)
IOWA (41)	5	(12%)	3	(7%)	8	(20%)	1	(2%)
KANSAS (66)	23	(35%)	15	(23%)	38	(58%)	10	(15%)
KENTUCKY (93)	9	(10%)	5	(5%)	14	(15%)	0	
LOUISIANA (32)	3	(11%)	2	(6%)	5	(16%)	0	
MAINE (19)	2	(11%)	0		2	(11%)	0	
MARYLAND (116)	40	(34%)	13	(11%)	53	(46%)	2	(2%)
MASSACHUSETTS (337)	42	(12%)	21	(6%)	63	(19%)	5	(2%)
MICHIGAN (300)	70	(23%)	25	(8%)	95	(32%)	12	(4%)
MINNESOTA (371)	23	(6%)	1	(.3%)	24	(6%)	0	
MISSISSIPPI (134)	57	(43%)	40	(30%)	97	(72%)	19	(14%)
MISSOURI (227)	47	(21%)	31	(14%)	78	(34%)	10	(4%)
MONTANA (83)	25	(30%)	4	(5%)	29	(35%)	0	
NEBRASKA (39)	19	(49%)	3	(8%)	22	(56%)	1	(3%)

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984 #	(%)	SNFs with 3 or more DEFICIENCIES 1984 #	(%)	TOTAL SNFs DEFICIENT 1984* #	(%)	SNFs CHRONICALLY DEFICIENT 1980-85** #	(%)
NEVADA (26)	3	(12%)	22	(85%)	25	(96%)	17	(65%)
NEW HAMPSHIRE (22)	1	(5%)	0		1	(5%)	0	
NEW JERSEY (245)	107	(44%)	60	(25%)	167	(68%)	39	(16%)
NEW MEXICO (14)	4	(29%)	0		4	(29%)	0	
NEW YORK (558)	45	(8%)	40	(7%)	85	(15%)	20	(4%)
NORTH CAROLINA (175)	47	(27%)	6	(3%)	53	(30%)	5	(3%)
NORTH DAKOTA (59)	29	(49%)	19	(32%)	48	(81%)	8	(14%)
OHIO (449)	41	(9%)	11	(2%)	52	(12%)	2	(.4%)
OKLAHOMA (12)	3	(25%)	0		3	(25%)	0	
OREGON (67)	11	(16%)	2	(3%)	13	(19%)	1	(2%)
PENNSYLVANIA (579)	82	(14%)	17	(3%)	99	(17%)	6	(1%)
PUERTO RICO (4)	2	(50%)	0		2	(50%)	0	
RHODE ISLAND (65)	9	(14%)	1	(2%)	10	(15%)	0	
SOUTH CAROLINA (104)	24	(23%)	10	(10%)	34	(33%)	3	(3%)

STATE (Total SNFs)	SNFs with less than 3 DEFICIENCIES 1984		SNFs with 3 or more DEFICIENCIES 1984		TOTAL SNFs DEFICIENT 1984*		SNFs CHRONICALLY DEFICIENT 1980-85**	
	#	(%)	#	(%)	#	(%)	#	(%)
SOUTH DAKOTA (67)	27	(40%)	22	(33%)	49	(73%)	16	(24%)
TENNESSEE (85)	14	(16%)	5	(6%)	19	(22%)	4	(5%)
TEXAS (239)	31	(13%)	9	(4%)	40	(17%)	5	(2%)
UTAH (45)	14	(31%)	22	(49%)	36	(80%)	17	(38%)
VERMONT (21)	3	(14%)	0		3	(14%)	0	
VIRGINIA (79)	9	(11%)	2	(3%)	11	(14%)	0	
WASHINGTON (245)	114	(47%)	74	(30%)	188	(77%)	47	(19%)
WEST VIRGINIA (41)	14	(34%)	7	(17%)	21	(51%)	3	(7%)
WISCONSIN (385)	44	(11%)	6	(2%)	50	(13%)	1	(.3%)
WYOMING (22)	9	(41%)	4	(18%)	13	(59%)	2	(9%)
NATIONAL TOTALS (8852)	2049	(23%)	987	(11%)	3036	(34%)	582	(7%)

* represents skilled nursing facilities in violation of one or more of 24 critical health, safety and quality standards.

** represents skilled nursing facilities in violation of at least three critical conditions in at least three of the last four inspections.

APPENDIX C

INCREASES IN VIOLATIONS OF CRITICAL STANDARDS AND REQUIREMENTS FOR MINIMALLY ACCEPTABLE NURSING HOME CARE

(1982 TO 1984)

Standard	Number of Violations		
	1982	1984	% Increase
PATIENTS DISCHARGED OR EVICTED FROM FACILITY WITHOUT LEGITIMATE REASON	49	98	+ 100%
PATIENTS DISCOURAGED/PROHIBITED, WITH THREAT OF REPRISAL, FROM EXERCISING THEIR RIGHTS	36	60	+ 66%
PATIENTS SUBJECTED TO MENTAL, PHYSICAL AND/OR CHEMICAL (DRUG) ABUSE	375	656	+ 75%
FACILITY FAILED TO PROVIDE ADEQUATE PHYSICIAN SUPERVISION OF PATIENTS	73	128	+ 75%
FACILITY FAILED TO PROVIDE ADEQUATE 24-HOUR NURSING CARE	181	292	+ 61%
FAILURE OF FACILITY TO PROVIDE ADEQUATE REHABILITATIVE NURSING CARE	625	954	+ 53%
FAILURE OF FACILITY TO MEET PATIENTS' NUTRITION AND FEEDING NEEDS	176	338	+ 92%
INADEQUATE CONTROLS AND RECORD-KEEPING FOR ADMINISTRATION OF DRUGS	100	145	+ 45%
FAILURE TO ADMINISTER DRUGS ACCORDING TO PHYSICIAN'S ORDERS	213	301	+ 41%
AGGREGATE TOTALS	**1828**	**2972**	**+ 63%**

APPENDIX D

SENATE SPECIAL COMMITTEE ON AGING

SELECTED KEY CONDITIONS, STANDARDS AND ELEMENTS FOR COMPLIANCE BY SKILLED NURSING FACILITIES

F15. Condition II -- The Skilled Nursing Facility (SNF) has an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility.

F62. Standard: Patients' rights. -- The governing body of the facility establishes written policies regarding the rights and responsibilities of patients.

F70 Element: Patient is transferred or discharged for legitimate reasons (medical, welfare of other patients) and is given reasonable advance notice.

F71 Element: Patient is encouraged and assisted to exercise his/her rights (voice grievances and recommend changes without interference, discrimination and reprisal).

F73 Element: Patient is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized by a physician (for limited time) or when necessary for protection of the patient and others.

F101 Condition IV. -- Physician Services. Patients are admitted only upon recommendation of, and remain under the care of, a physician.

F105 Standard: Patient Supervision By Physician.

F111 Element: Patient's total program of care (drugs & treatments) is reviewed by a physician every 30 days for the first 90 days, and revised as necessary.

F112 Element: A progress note is written and signed by the physician on each visit, and the physician signs all orders.

F123 Condition V. -- Nursing Services. The SNF provides 24-hour service by licensed nurses (services of an RN at least during the day tour of duty 7 days a week. There are enough nurses to meet the total nursing needs of all patients.

F134 Standard: Twenty-four-hour nursing service.

F135 Element: 24-hour nursing services to meet total nursing needs.

F136 Element: nursing policies ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, cleaned, well-groomed, and protected from accident, injury, and infection.

F173 Standard: Rehabilitative Nursing Care.

F175 Element: an active program of rehabilitative nursing care and is directed toward each patient achieving and maintaining an optimal level of self-care and independence.

F176 Element: Rehabilitative nursing care services are performed daily for those patients who require it, and are recorded routinely.

F177 Standard: Supervision Of Patient Nutrition.

F178 Element: Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist where needed in feeding patients.

F180 Element: Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and physician.

F181 Standard: Administration Of Drugs.

F182 Element: Drugs and biologicals are administered only by physicians, licensed nursing personnel, or by personnel with State-approved training.

F186 Element: administration of a drug is properly recorded by the person administering.

F189 Standard: Conformance with physicians' drug orders.

F190 Element: Drugs are administered according to written orders of the physician.

F191 Element: Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies.

APPENDIX E

SENATE SPECIAL COMMITTEE ON AGING

SELECTED KEY STANDARDS AND ELEMENTS FOR COMPLIANCE BY INTERMEDIATE CARE FACILITIES

XII. PHYSICIAN SERVICES

T94 Standard: Physician Services. The facility assures that each resident's health care is under the continuing supervision of a physician who sees the resident at least once every 60 days, unless justified otherwise.

XIII. HEALTH SERVICES

T95 Standard: Health Services. The facility provides health services which assure that each resident receives treatments, medications, diets, and other health services as prescribed and planned.

T103 Standard: Health Care Plan. A written health care plan is developed and implemented by appropriate staff for each resident.

T105 Standard: Nursing Service. Nursing services, including restorative nursing, are provided in accordance with the needs of the residents.

XIV. DIETETIC SERVICES

T117 Standard: Sanitary Conditions. All food is procured, stored, prepared, distributed, and served under sanitary conditions.

T118 Standard: Self-Help Devices. Individuals needing special equipment, implements, or utensils to assist them when eating have such items provides.

XV. DRUGS AND BIOLOGICALS

T127 Standard: Automatic Stop Orders. Medications not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies and the attending physician is notified.

T129 Standard: Medication Review. A registered nurse reviews monthly each resident's medications and notifies the physician when changes are appropriate.

XVI. RESIDENT RECORD SYSTEM

T135 Standard: Content. There is a record for each resident.

T139 Element: The record contains assessments and goals of each service's plan of care and modifications.

T143 Element: The record contains entries describing treatments and services rendered.

T144 Element: The record contains entries on medications administered.

XVIII. ENVIRONMENT AND SANITATION

T152 Standard: The facility maintains adequate conditions relating to environment and sanitation.

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T163 Element: Temperatures of hot water at plumbing fixtures used by residents is automatically regulated by control valves.

T164 Element: Corridors used by residents are equipped with firmly secured handrails.

T165 Element: Provision is made for isolating residents with infectious diseases.

T169 Standard: Facilities for Physically Handicapped. The facility is accessible to and functional for residents, personnel, and the public.

APPENDIX F

DHHS Inspector General

Selected Key Conditions, Standards and Elements for Compliance by Skilled Nursing Facilities

Selected Conditions of Participation

- Medical Direction
- Physician Services
- Nursing Services
- Dietetic Services
- Pharmaceutical Services
- Physical Environment (includes Life Safety Code)
- Infection Control

Selected Standards

Physician Services

- Patient supervision by physician
- Availability of physicians for emergency patient care

Nursing Services

- Director of nursing services
- Charge nurse
- 24 hour nursing service
- Patient care plan
- Rehabilitative nursing care
- Supervision of patient nutrition
- Administration of drugs
- Conformance with physician drug orders
- Storage of drugs and biologicals

Dietetic Services

- Staffing
- Menus and nutritional adequacy
- Therapeutic diets
- Frequency of meals
- Preparation and service of food
- Hygiene of staff
- Sanitary conditions

Pharmaceutical Services

- Supervision of services
- Control and accountability
- Labeling of drugs and biologicals

Physical Environment

- Emergency power
- Nursing unit
- Facilities for special care
- Maintenance of equipment, buildings, and grounds.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY

The attached may be of interest to you.

Office of the Assistant
Secretary for Legislation

Room 416-G H. H. Humphrey Bldg.
200 Independence Ave., S.W.
Washington, D.C. 20201

[COMMITTEE STAFF NOTE: The attached document was delivered to the Committee and released to the press in early October, 1986. The document does not contain its Attachments #1 and #2; for the complete document, please see the copy requested by the Committee and delivered November 21, 1986, elsewhere in this Appendix.]

Response to the Senate
Special Committee on Aging
Staff Report on Nursing Home Care

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Attachments

1. Number of Deficiencies in the Critical Requirements Identified by the Senate Special Committee
2. SNFs with Conditions of Participation Out of Compliance
3. Initiatives to Improve MMACS

EXECUTIVE SUMMARY

- We strongly disagree with the report's conclusion that many nursing homes are egregiously substandard. The American public can be confident that we make every effort to ensure our elderly receive quality care in a safe environment.

- The report concludes that one-third of certified nursing homes are substandard. This conclusion is, at best, based upon indefensible subjective judgments. There is absolutely no reason to believe that this is the state of America's nursing homes. Furthermore, any facility found to be substandard is vigorously forced either to correct the problem or face termination from Medicare and/or Medicaid.

- The report concludes that there are 582 (7%) "chronically deficient" SNFs because they are "in violation of at least three critical conditions..." Our data indicate that there are no SNFs deficient in these three conditions.

- The report further alleges that in 1984, 3036 (34%) of certified SNFs failed to comply with "the most essential" of the many Federal health, safety, and quality standards, and that 100 (11%) of these SNFs were cited for violating three or more "critical minimum standards." HCFA cannot respond specifically to these allegations at this time since the Committee's data is constructed differently from the HCFA data base, and is outdated. However, we completed an analysis of current data on both the committee's critical requirement list and our own list of critical requirements. This analysis revealed that:

    - Using the committee list, 61% of all deficiencies cited on initial survey had been corrected prior to certification and 38% had an approved plan of correction, accounting for 99% of all critical deficiencies.

    - Using the HCFA list, 64% of deficiencies were corrected and 35% had an acceptable plan of correction, again accounting for 99% of identified critical deficiencies.

    - Data in the report are obsolete since they are from 1982-1984. While HCFA is conducting its own analysis using current data, it is difficult to replicate whatever the committee staff used in reaching its conclusions.

- The report fails to mention the wide range of enforcement efforts States take under their licensure laws in concert with Federal regional offices to deal with substandard facilities. These efforts include fines, State receivership, and other civil and criminal penalties.

By ignoring the excellent Federal/State enforcement records, as well as the hard work of consumer advocates and a majority of the nursing home industry, the report does the nation's elderly a major disservice. By presenting such an inaccurate view, it unjustly erodes their confidence in a system which is working to assure Americans that they can have confidence in the quality of the care they will receive in certified nursing homes.

- The committee staff have so far refused to identify to HCFA which facilities were examined in their "case studies." When we receive a complaint or other information about problems in a facility, we react immediately to investigate. By refusing to identify the facilities cited, committee staff have, in effect, hindered any corrective action we might take and, frankly, subjected these "studies" to some skepticism.

- Committee staff never discussed the report with program management in an effort to understand more fully the data or issues they were analyzing. This contributes to some of the fundamental flaws in the analysis and conclusions.

- The report deliberately avoids any discussions with groups or individuals who might have something good to say about Federal/State efforts to enforce nursing home requirements. Even such groups as the National Coalition for Nursing Home Reform and the American Association of Retired Persons have been excluded. This is particularly interesting since these groups are the principle consumer representatives and, we believe, have been generally satisfied with our efforts.

- The report neglects to even discuss the many initiatives HCFA and the states have taken to ensure quality care for our nation's nursing homes. In particular, HCFA has taken an extremely aggressive posture over the last 3 years which the report neglects to mention:

    - Issued new termination procedures to State agencies. These procedures streamline the process to terminate a facility from Medicare.

    - Issued "Look-Behind" procedures to Federal staff. In cases where the State has not performed its survey responsibilities properly, these procedures enable the Federal government to move quickly against a substandard facility--especially when it is endangering patients' lives.

    - Developed a new long term care survey process. The new Patient Care and Services (PaCS) survey process focuses surveyor attention on outcomes--the care status of patients as opposed to just structural and procedural items.

- Established new agreements with States so that States would understand exactly what they were expected to do in enforcing Federal requirements.

o These initiatives indicate that HCFA shares the Committee staff's desire to assure that care of the highest quality is provided to every Medicare beneficiary and Medicaid recipient in the nation's certified skilled nursing facilities. Substandard care provided to even one elderly patient cannot be tolerated.

o Many of the committee staff's recommendations are similar to those found in the study on the quality of care in nursing homes from the Institute of Medicine. HCFA contracted with the Institute of Medicine to conduct this study, and is currently analyzing the voluminous report which was recently completed at a cost of $1.6 million.

INTRODUCTION

Culminating a 2-year investigation of the state of nursing home care in the United States, the Senate Special Committee on Aging has recently held hearings and released a staff report summarizing its findings. Entitled "Nursing Home Care: The Unfinished Agenda", the report contains a number of specific policy recommendations aimed at improving the quality of care in nursing homes.

We agree that further improvements in the nursing home quality assurance system are desirable and, in fact, have taken action prior to the Committee's report to implement some of its recommendations. However, we strenuously object to the sensationalistic tone of the report - such as the Committee's characterization of nursing homes as 19th century asylums - and its implied theme that Federal and State quality assurance efforts have not been effective in improving overall quality of care in nursing homes.

We dispute the report's fundamental assertion that "bed, board and abuse" have been allowed to replace proper medical and rehabilitative care in certified facilities. A general consensus exists that, although there is still room for improvement, the past decade has witnessed substantially upgraded conditions in the nation's nursing homes. For example, the Institute of Medicine's (IoM) Committee on Nursing Home Regulation released in February 1986 a comprehensive report aimed at problem identification and solution in nursing home quality assurance. The IoM committee consisted of twenty individuals with substantial and diverse knowledge and experience in the nursing home field; its report was referenced on several occasions by the Committee on Aging's staff report. While acknowledging the continuing problem of instances of substandard care, the IoM report offered a much more balanced perspective:

"Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the Committee and of resident advocacy organizations, is that the disturbing practices that were all too common a decade ago now occur less frequently...." "These observations do not mean either that the picture of American nursing homes is entirely gloomy or that the regulatory efforts of the past decade have been entirely unsuccessful. Today, many institutions consistently deliver excellent care. Good care can be observed in all parts of the country; it exists under widely varying reimbursement systems and all types of ownership...." "Nursing homes were essentially unregulated in most States prior to the late 1960s... and the quality of care was appalling...."

"There is consensus that regulations have made a positive contribution, although reliable comparative data are not available to support this judgment. The committee found that the consumer advocates, providers,

and State regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974. But there is substantial room for improvement."
The evenhandedness of the IoM report, prepared by a bipartisan group of acknowledged experts, stands in sharp contrast to that of the Special Committee on Aging.

We also believe that the Committee's report tends to rely on selective and often incomplete data interpretation in support of pre-established premises. This paper examines several of the report's fundamental flaws, notably the lack of attention to or understanding of the deficiency correction methodology and reporting system, and the overreliance on the "critical requirement" concept for assessing the severity of identified deficiencies. In addition, the report purports to "establish the depth and severity of persistently dangerous and unhealthful conditions" for 15,000 nursing homes via four unidentified case studies that constitute a full third of its findings.

The report's basic conclusion is that "tens of thousands of patients" are living in "squalid conditions" in nursing homes that "resemble 19th century asylums". We believe that this is an unfortunate misrepresentation of the overall quality of nursing home care in this country. By undermining public confidence that quality care in a safe environment is available, the report does a grave disservice to ill and elderly Americans and their families as well as to the vast majority of the nation's nursing homes. The Committee's conclusions were apparently drawn using data independently obtained from the HCFA database, the Medicare/Medicaid Automated Certification System (MMACS). The information in the report was never discussed with HCFA program management in an effort to more fully understand the data or issues being analyzed. Instead, the Committee went to third party sources (i.e., GAO and the Inspector General of HHS) who merely accessed the data system. Consequently, the information presented is distorted, misleading, and, at best, outdated by 2 - 4 years, contributing to some of the fundamental flaws in the analyses and conclusions. Because we do not know the methods used by the Committee staff to collect and analyze the data, we have been unable to replicate it. We can, however, based on our knowledge of the survey and certification process and our current data statistics, refute many of the committee report's conclusions.

We are committed to working with the States, the nursing home industry and consumer advocates to pursue continued improvements in nursing home quality of care. However, we believe that Federal certification of a facility is today a reliable indication of acceptable quality care.

RESPONSE TO SPECIFIC ISSUES

The following are our specific reactions to the major issues in the report:

- "Tens of thousands of patients in nursing homes still suffer from the poor nutrition, inadequate nursing care and squalid conditions thought to have been corrected long ago by State and Federal reforms."

  The above statement was presented as Problem #1 in the body of the Report. To support this general conclusion that many nursing homes are grossly substandard, the committee devoted one-third (16 pages) of the report to 4 case studies alleged to be representative of some 15,000 long term care facilities. Because the identity of these facilities was not disclosed in the report, we contacted the committee for the names of the four nursing homes in order to investigate, first hand, the conditions of the facilities and, if necessary, take corrective action as soon as possible.

  However, the staff refused to furnish the information, preventing us from validating the data and taking corrective action if appropriate. This unwillingness on the part of the committee staff to assist us in investigating these facilities that are allegedly providing "grossly inadequate care resulting in humiliation, suffering and premature death" raises serious questions regarding the actual intent of the report and the validity of the data.

- "...there has been a dramatic increase in violations of major conditions.... Despite the high numbers of violations, the federal government decertified about 200 nursing homes in 1985, with most choosing voluntarily to close."

  As a basis for making this sweeping statement, the Committee attached a chart containing nine statements identified as "critical standards and requirements for minimally acceptable nursing home care." Accompanying the statements are some figures dating back to 1982 and 1984 showing the number of violations of each "requirement" for each year along with a percentage of increase. The report's interpretations of these requirements constitute deliberate distortions of the actual Federal requirements. In addition, the simplistic comparisons of aggregate deficiency data from different years are equally misleading.

  For example, from a list of "key" requirements, which the committee personally compiled, they cite the following as a key standard for measuring minimally acceptable care:

  > "(F70) Element: Patient is transferred or discharged for legitimate reasons (medical, welfare of other patients) and is given reasonable advance notice."

The Committee's chart inverts and embellishes this statement to read:

> "Patient discharged or evicted from facility without legitimate reason.

The actual requirement as it reads on the Federal survey form is as follows:

> (F70) Is transferred or discharged only for medical reasons, or for his or her welfare or that of other patients, or for nonpayment for his or her stay (except as prohibited by Titles XVIII or XIX of the Social Security Act) and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in the medical records.

(The underlined portions were arbitrarily omitted from the Committee's version of this requirement.)

F70 is the computer data tag for that requirement which will show up as deficient in the Medicare/Medicaid Automated Certification System (MMACS). This requirement could be easily marked deficient during a survey, although a transfer of the resident was properly performed. Documentation in the medical record could have been unclear, misplaced, or sitting on someone's desk, but because it was not there at the time of the review, the surveyor would cite the element deficient. Using MMACS data as the committee used it, this deficiency (i.e., F70 in MMACS) would have been translated by the committee as "patient discharged or evicted from facility without legitimate reason." The other eight "standards" in the Committee's chart were reinterpreted in a similar fashion, distorting the intent of the underlying requirements and the overall picture of nursing home care.

Even if the standards were properly stated and the outdated figures verifiable, the aggregate deficiency comparisons presented in the accompanying charts in no way constitute legitimate evidence of deterioration in nursing home care. The report makes no mention of a number of legitimate reasons for increases in deficiency citation including the addition of almost 1000 new facilities, and 100,000 beds since 1982, and an increase in numbers of surveys performed.

- Terminations

The committee produced a chart indicating the number of involuntary terminations that occurred in skilled nursing facilities between 1980 and 1985. The results of our data analysis differ considerably from the committee's findings. Following is a comparison of the Committee's figures on involuntary SNF terminations with ours:

	1980	1981	1982	1983	1984	1985	1986 (as of 5/86)
Committee Figures	45	26	10	7	11	3	Not available
HCFA Figures	56	32	20	10	27	28	14

The report also indicates that only about 200 long term care facilities (i.e. SNFs, ICFs, and ICFs/MR) were decertified in 1985, with most choosing voluntarily to close. In actuality, 296 facilities were decertified in 1985. Facilities will often choose to terminate voluntarily rather than be involuntarily terminated and will do so before involuntary termination procedures are completed.

o "... in 1984 over one-third of the nation's certified nursing homes failed to fully comply with the most essential health, safety, and quality standards of the Federal government.... the Committee staff estimate is conservative because the Federal database underreports the extent of substandard care being provided in nursing homes."

To arrive at these misleading conclusions, the Committee, in concert with GAO and the Inspector General of HHS, drew up a list of their own "critical" health and safety standards (what they felt to be most directly related to patient well-being.) Presumably, if a facility was not in compliance at the time of survey with one or more of the Committee's designated critical requirements, that facility was listed as failing to "fully comply with the most essential health, safety, and quality standards of the Federal government." Disregarding the fact that only 7 of the Committee's 25 key requirements are on our own critical requirement list, there are a number of additional reasons why such a conclusion is seriously misleading.

Throughout the report, in its analysis of cited deficiencies, the committee fails to mention whether any of these deficiencies were corrected, or had an acceptable plan of correction prior to certification. The correction procedure is an integral part of the survey and certification process and a key consideration in determining the condition of our nursing homes and whether HCFA is properly performing its function of assuring quality care.

Because 1984 data is unavailable, we did a current analysis using the committee's own list of critical requirements. Of all the deficiencies cited at the time of survey, 61% were subsequently corrected and 38% have an acceptable plan of correction which accounts for 99% of all the "critical" deficiencies cited (see Attachment 1). We did a similar analysis on our own list of critical requirements and found that 64% had been corrected and 35% had an acceptable plan of correction, again accounting for 99% of all critical deficiencies cited. Also, the committee's report fails to point out that if surveyors find problems sufficiently serious to endanger patients, they are instructed to either have the facility resolve the problem immediately or begin termination action. We know that the vast majority of deficiencies cited at the time of survey are either corrected or have an acceptable plan of correction at the time of certification.

We recently did some analysis on all Conditions of Participation that were being reflected in MMACS as out of compliance. Based on a regional review of the actual case files, we found that only a small fraction of the number reflected in the system was actually of out compliance. The biggest problem in most regions was getting the revisit reports (which contain deficiency correction data) entered into MMACS on a timely basis.

This data entry problem is due in a large part to heavy workloads. Entry of revisit reports has traditionally been viewed as "paper" (record) correction and as such is usually assigned a lower priority than, for example, entering (re)certifications which affect facility reimbursement, or other functions that are more directly related to the health and safety of patients. Thus, rather than underreporting the extent of substandard care, as the committee alleges, the database actually overreports existing problems.

Another major omission from the report is any explanation of how a deficiency is cited and exactly what the citation means. The committee's specific selection criteria or rationale for its 25 designated critical requirements was not disclosed in the report other than to say they felt these to be most directly related to patient well-being. Fifteen of those 25 requirements were at the element level. For SNFs, there are 328 elements making up 84 standards comprising 18 conditions. The element is by definition the least serious type of deficiency, used by surveyors to point out specific minor infractions that could, in the aggregate, eventually lead to care problems. It is only after reviewing citations at the element level that the surveyor is able to evaluate the degree of non-compliance and make a judgment regarding the facility's compliance with the related standard or condition which, if cited as deficient, would indicate a more serious problem in that area. The surveyor would then consider the degree of compliance of related standards to determine whether the pertinent condition overall was met or not met.

For example, there could be 1,000 cited deficiencies in what the committee considered a critical element. However, the majority of those citations may be for very minor infractions which a conscientious and well-trained surveyor would cite but which would in no way affect the compliance status of the related standard or condition.

One of the elements the committee identified as key or critical deals with rehabilitative nursing care and reads as follows:

> Rehabilitative nursing care services are performed daily for those patients who require it, and are recorded routinely (F176).

A surveyor could enter the facility and determine that rehabilitative nursing care services are performed daily on patients requiring them, but because a nurse, on a particular occasion simply failed to record the service, the surveyor would cite the omission at the element level. For the Committee's purposes, that facility would be considered in violation of a critical requirement for minimally acceptable nursing home care when, in fact, rehabilitative nursing care services are intact and appropriate.

Because the committee's list of "critical" requirements, with 60% at the element level, is not an accurate gauge for measuring "minimally acceptable nursing home care," we performed our own analysis on the requirements that by regulation measure minimally acceptable care--the Conditions themselves.

- Analysis of Conditions of Participation

Although there were only three conditions cited on the committee's list of critical requirements--Governing Body (F15), Physician Services (F101), and Nursing Services (F123), our analysis encompassed all 18 SNF conditions. The results of that analysis (see Attachment 2) indicate that 89% of the COPs out of compliance at the time of survey were corrected, and the corrections were processed to MMACS. Of the remaining 11%, most were corrected, but not yet reflected in MMACS due to delays in data entry.

- Problems with MMACS

In its report, the committee frequently alludes to the lag time in having recent survey data reflected in MMACS and indicates that HCFA does not use the system to monitor nursing homes or State survey agencies. However, since 1984, we have developed several initiatives to improve the timeliness and accuracy of the information in the MMACS database and to step up the use of MMACS as a monitoring tool. These initiatives are discussed in detail in Attachment 3.

COMMITTEE RECOMMENDATIONS

The committee concludes their report with a list of staff recommendations. In its zeal to identify shortcomings in the enforcement of program requirements by HCFA and the States, the committee has failed to recognize the efforts taken in recent years to upgrade the overall quality of care being furnished program beneficiaries, including two of the most publicized changes in the history of the certification program--the new resident centered and outcome-oriented inspection process in nursing homes and new, streamlined termination procedures. Also ignored have been the efforts to involve all affected groups in the policy-making process. Although an "open" process consumes more time, the policies emanating reflect the reality of the needs and demands of the States, consumers, and the health industry.

Following are the Staff Recommendations and a synopsis of what we have developed and/or implemented in each of these areas:

o Strengthen the nursing home inspection system

Within the last two years, the enforcement process has been considerably strengthened and other initiatives under development will strengthen it further.

1. In December, 1985, after almost two years of meetings, proposals, and counter-proposals, the procedures for terminating Medicare participation were revised. Existing procedures were replaced with a more streamlined process developed around processing time limits. We developed a tracking system to monitor regional office and State agency adherence to the procedures. The new procedures not only require an accelerated process (23 days) following a determination that a facility's deficiencies pose an immediate and serious threat to patient health and safety, but almost as importantly, they balance the rights of the beneficiaries, the providers, and the Government to ensure that all parties receive the full measure of the protections afforded by the Social Security Act.

2. We strengthened the procedures for implementing the Secretary's authority to "look behind" Medicaid determinations. We revised procedures to provide a more uniform approach to the application of this authority. These new procedures enable HCFA to take quick and decisive action when Federal look behind surveys countermand State findings.

3. We completed the updating of our program manuals for the State agencies and HCFA regional offices. Up-to-date instructions assure a more uniform and consistent interpretation, application, and enforcement of program requirements.

4. We revised the contract executed between the Secretary and the States that specifies the survey and certification functions of the Medicare State survey agency. This contract, which had not been revised since the early 1970s, is referred to as the Section 1864 Agreement. The revised Agreement is not only explicit in delineating survey agency responsibilities, but it now enables the Secretary to terminate all or part of the Agreement if the Secretary finds that the survey agency is not meeting its survey and certification responsibility.

5. The role of the surveyor was clarified by the issuance of a policy statement emphasizing that the primary role of the surveyor is to apply and enforce program requirements rather than act in a consultative capacity in assisting facilities to correct deficiencies. Surveyor efforts to provide assistance to facilities led some providers to believe that it is in the government's role to assist the providers in achieving and maintaining compliance. The new policy clarifies that the government's job is to determine what problems exist and to identify those problems (deficiencies). Developing appropriate plans of correction and achieving corrections, as promised, is the responsibility of the providers.

6. Throughout 1985 and into 1986 training efforts were increased. Regional office and State agency staff were trained in the new long term care survey process and termination procedures. Staff also received training designed to enhance current skills. Over half of the surveyors received nationally sponsored training.

7. The survey method for determining whether or not a skilled nursing or intermediate care facility meets program participation requirements has been revised. The new survey process is resident centered and outcome-oriented and assesses facility compliance by evaluating the quality of care and services actually being furnished to residents. The process was developed and tested over several years and will be implemented beginning in July 1986.

- Mandate improved State response to consumer complaints and requests for inspection and cost reports

A process that will enable the timely processing, investigation and resolution of complaints is under development. Complaints represent a relatively untapped resource of information on the quality of care and services being furnished. Complaint data will be used as an integral ingredient in the enforcement process since it provides information on facility compliance during the interval between onsite surveys. In creating an effective system, we must however make it compatible with complaint systems already in place in the States.

- Authorize a full array of "intermediate sanction" penalties and receivership authority, so a measured incremented enforcement approach can be taken by inspectors, and substandard homes can be improved without relocating all the residents of these facilities.

  This year we will implement a ban on new admissions as an alternative to termination if deficiencies do not immediately jeopardize patient health and safety. The ban will be used for providers who have demonstrated, historically, the ability to correct cited deficiencies. This provision will reduce the need for termination and the consequent need for patient relocation.

- Elevate "resident rights" to a condition of participation and strengthen these rights.

  The proposal to change the current Conditions of Participation by elevating Resident Rights from a Standard to a Condition of Participation is under active consideration by HCFA. This change may increase the significance of deficient findings. In effect, this action will strengthen resident rights since facilities which violate resident rights will be more likely to jeopardize their continuing status in the program. This will not provide "new" rights since all constitutional and legal rights are maintained while residents are in nursing homes, and these guarantees are protected by means other than a new regulation. However, rights requirements in this proposal emphasize that residents do not give up any rights while confined to a nursing home. Finally, in concert with this perspective, the rights statement can be expanded to emphasize residents rights to self-determination and choice. It may also be necessary to accentuate these rights by restating them and identifying the facility's responsibilities for maintaining these rights elsewhere in requirements.

- HCFA should issue instructions to the State agencies and HCFA regional offices, informing them of their obligation to enforce existing laws, such as (1) penalties for repeat offenders; and (2) prohibitions against Medicaid discrimination.

  1. This proposal corresponds with the IoM study's recommendation that we take action against providers who are cited year after year for repeat deficiencies. Prior to receipt of the IoM, we had developed our own proposal for dealing with providers - all providers not just long term care facilities - who have demonstrated the unwillingness or inability to maintain compliance. Our proposal, if implemented as a regulation, will enable us not only to terminate participation for the repeated failure to meet the same or different requirements in successive years, but it will bar readmission to the program for specified periods of time.

2. In concert with the Under Secretary's Task Force, HCFA is analyzing the full range of issues relating to Medicare discrimination, including the scope of the problem and related administrative and legislative issues.

- HCFA should expand the hospital swing-bed program, to (1) ease the tight bed supply situation that facilitates illegal discriminatory practices; (2) increase competition in the industry, so quality can be more of a factor in the marketplace.

The Rural Swing-Bed Program was congressionally mandated by the Omnibus Reconciliation Act of 1980. The legislation permits hospitals with fewer than 50 beds that are located in rural areas with a shortage of long term care beds to "swing" their beds between acute and long term care as needed. The program is to extend from September 1983 to November 1987. An evaluation of the project will assess the impact on:

+ Access to long-term care beds in rural areas
+ Quality of long-term care in hospitals
+ Cost of services in swing-bed hospitals
+ Program-wide costs
+ Administrative costs to administer and monitor the program.

Based on the findings and recommendations, Congress will decide whether to continue the program or extend it to larger hospitals. The first evaluation report is expected in late 1986.

Attachment 3

Initiatives to Improve MMACS

- Front End Data Entry

  In March 1985, we made an important change in how certification kits are processed in the regional offices. Regions are now required to enter all recertifications into MMACS upon receipt in the regional offices prior to review by certification specialists. This process is called "front-end data entry". Computer-based flags automatically screen recertification cases for critical requirements, including Conditions of Participation. Cases failing the screen are subjected to indepth professional review. Cases passing the screen require no professional review after entry into MMACS. Because the cases are being entered into MMACS as soon as they are received in the ROs, the lag time in entering certifications has been significantly reduced.

- Case Control System

  In conjunction with the "front-end data entry process", we developed a standardized MMACS-based case control system in September 1985. This system provides central and regional office management with important information for monitoring certification activity and identifying processing bottlenecks. In addition to providing summary data on the number of recertification cases that are received, cleared, pending, and pending over 30 days in the regional offices, the case control reports also identify cases that are due from the States. This enables the regions to identify any recertification cases that have not been forwarded by the States within prescribed timeframes.

- SA Direct Data Entry

  Delays can occur from the time the survey takes place to when the results are forwarded to the regional offices for review and data entry. To eliminate unnecessary paperflow and facilitate timely data entry, we began a pilot project in 1984 in four States to test the feasibility of transferring the responsibility for data entry from the regions to the States. The demonstration has been successful and we plan to increase the number of participating States this year. We expect that all States will be entering the data directly into MMACS within two years.

Attachment 3 (cont'd)

- Adverse Action Extract, HCFA-462

  Recently, we developed a new form (HCFA-462) to ensure the prompt processing of certification actions where there is the potential for adverse action (terminations and denials of payments for new admissions (alternative sanctions)). The pertinent information from the form will be entered into MMACS, and based on our analyses of the data, if the State agencies or regional offices fail to process these actions in accordance with manualized processing time limits, their failure will be documented and brought to their attention for corrective action during tne State and RO evaluation programs.

- Federal Monitoring Survey System (FMS)

  The FMS system, a subsystem of MMACS, was recently revamped in order to provide central and regional offices with essential information from direct Federal surveys. The data from this system will assist in:

  - assessing the overall effectiveness of the State survey program;
  - analyzing the effects of national survey policies/procedures;
  - monitoring problem providers; and
  - performing regional comparisons to see if Federal guidelines are being applied uniformly.

  The FMS system was designed to analyze the results of the direct surveys conducted by the regional offices, automatically comparing their findings with State conducted surveys.

- Survey and Certification Operations Report (SCOR)

  In July, 1985 we issued the first in a continuing series of quarterly reports to the Regional Administrators and top level HCFA management on certification activities in the ROs. The SCOR focuses on various aspects of certification activity each quarter using MMACS as its primary data source. Through the SCOR we have been alerting the regional offices to excessive processing times, processing bottlenecks, deficiency trends, improper processing and/or certification procedures, etc. When significant problems are uncovered through analysis of SCOR (i.e. MMACS data), followup memoranda are sent to the ROs outlining the problem and recommending specific actions to be taken.

- Future MMACS Enhancements

  - Over the next few years, we plan to expand and upgrade the MMACS to be a more effective and efficient state-of-the-art management information system. Our plans include modifying the data base to capture more patient specific information and less statistical and deficiency related information. We will focus our attention on outcomes of patient care rather than on facility compliance with the traditional structure and process requirements.

  - Another way we plan to enhance the data system is to streamline the data collection and entry techniques. As mentioned previously, within two years we expect all the States to be entering the survey results directly into the data base instead of forwarding the hard copies to the regional offices for review and data entry.

  - This year we plan to use data from MMACS, almost exclusively, to evaluate our regional offices' performance. We also have plans to computerize the State agency review process.

MEMORANDUM -- F Y I

November 4, 1986

TO: Stephen McConnell, Staff Director
Special Committee on Aging, U.S. Senate

FM: David Schulke, Investigator
James Michie, Chief Investigator

RE: **Analysis** of a paper, "Response to the Senate Special Committee on Aging Staff Report on Nursing Home Care."

The Department of Health and Human Services (DHHS) recently provided Aging Committee staff with a copy of a paper which attempts to rebut the findings of the May 1986 Committee staff report, "Nursing Home Care: The Unfinished Agenda." The paper is titled "Response to the Senate Special Committee on Aging Staff Report on Nursing Home Care," and was drafted by personnel within the Health Care Financing Administration (HCFA).

Aside from objecting to the tone of the Committee staff report, the paper takes issue with some of the findings of the Committee staff report on quality of care in nursing homes. We have found that their objections are without merit. An analysis of each of the criticisms contained in the HCFA paper follows:

HCFA COMPLAINT #1.

The HCFA paper contained aggregate data from analyses of its own data base, and suggested that its aggregate data contradicted the GAO/Committee staff analyses. The HCFA paper stated: "We completed an analysis of current data on both the Committee's critical requirement list and our own list of critical requirements. This analysis revealed. . ." that 99% of all deficiencies cited on the initial survey had been corrected prior to certification or had an acceptable plan of correction.

COMMITTEE STAFF ANALYSIS

- By law, every violation of the minimum health and safety standards found in nursing homes by inspectors must be corrected for the facility to remain certified. This does nothing to alter the fact that the nature and extent of health code violations is important to analyze: violations of essential requirements that jeopardize patient health and safety should rarely occur, if ever, and should not recur.

- Committee staff analysis confirmed what GAO, the DHHS IG, and HCFA itself have found: many facilities repeatedly violate the same requirements after reportedly "correcting" the deficiencies. This calls into question the utility of HCFA's method of assuring that actual and lasting corrections are in fact implemented.

- o Committee staff review of hard copy inspection reports, complete with facility "plan of correction", revealed that these plans are frequently non-specific, non-responsive, or simply parrot regulatory requirements. A major study of California's 1,000 certified SNFs drew similar conclusions in 1984.

In addition to the Committee staff analysis of HCFA's performance records for thousands of SNFs, testimony by GAO and the DHHS Inspector General, as well as a 1986 internal HCFA report, confirm the existence of many repeatedly and chronically substandard facilities, a finding which calls into question HCFA's characterization of "corrections". HCFA's own report stated in January 1986:

> " . . .It is apparent from these monitoring surveys that there are some long-term care facilities that are habitually out of compliance with the regulations, bringing themselves into compliance only temporarily prior to State Agency follow-up visits. Subsequently, they become out of compliance." [Emphasis added; from HCFA Comprehensive Evaluation Report dated January 31, 1986].

GAO offered this description of the very same problem:

> "nursing homes with a history of deficiencies that jeopardized patient health and safety and/or seriously limited their capacity to provide adequate care were able to remain in the Medicare or Medicaid program by taking corrective action that allowed them to be recertified. These homes, however, were often later found to have the same or similar deficiencies." [Emphasis added; excerpt of GAO testimony of May 21, 1986]

The State of California's 1984 Little Hoover Commission report on nursing home enforcement, and staff review of inspection reports, indicate that the States and HCFA have accepted as a valid "plan of correction" almost anything the provider wishes to write down. Outright denials of the violation, stock promises of upcoming "inservice" training, parroting of regulatory language -- all are devices used to satisfy surveyors that they can check off the plan of correction paperwork and get on to the next facility.

HCFA COMPLAINT #2.

HCFA says the Committee investigation finding that 582 (7%) of SNFs are chronically deficient "because they are 'in violation of at least three critical conditions...'" is wrong because HCFA's "data indicate that there are no SNFs deficient" in "these three critical conditions".

COMMITTEE STAFF ANALYSIS

Testimony and evidence presented at the Committee's May 21, 1986 hearing, as well as evidence amassed by GAO, the DHHS Inspector General, state inspectors and the Institute of Medicine, clearly validate the Committee staff findings and reveal that HCFA is wrong in suggesting that that "no SNFs" are chronically in violation of critical conditions.

- The DHHS Inspector General identified 740 chronically substandard nursing homes from HCFA's database, and verified this finding by reviewing inspection reports for these facilities;

- The Los Angeles County survey and certification chief testified to the existence of a hard core 10% of repeat offender nursing homes.

- The Institute of Medicine (IOM) reports that its six state studies show 10 to 15% of nursing homes (including ICFs) have "chronic problems" maintaining compliance with health and safety standards.

HCFA should undertake immediate efforts to ensure that meaningful corrections to health code violations are achieved in reality, and not simply on paper. These reforms should, at minimum, include the following: (1) HCFA needs to begin a national effort to identify chronic and repeat offender nursing homes from the inspection information in its database immediately. (2) HCFA should instruct States and Regional Offices to use existing Federal authority to restrict provider agreements for nursing homes that repeatedly violate the same or similar health and safety regulations. (3) HCFA should aggressively seek legislative authority for fines and penalties for use on such providers. In addition, HCFA should read and respond specifically to the other recommendations in the Committee staff report.

HCFA CRITICISM #3.

The HCFA paper takes issue with what it identifies as a "conclusion" of the Committee staff report: "one-third of certified nursing homes are substandard." The HCFA paper asserts, "This conclusion is, at best, based upon indefensible subjective judgements."

COMMITTEE STAFF ANALYSIS

- The Committee staff list of regulatory requirements rated very high on a list of criteria that are critical to good patient care, according to an independent analysis by GAO.
- Applying HCFA's own "critical requirements" list to the data base revealed that one-half of certified SNFs violated one or more of these requirements during the most recent survey.
- While substandard care is prevalent according to Federal inspection reports, the most important finding of the Committee staff study is that between 580 and 740 skilled nursing facilities are chronically substandard.

HCFA's contention that the finding of the extent of substandard care is "based upon indefensible subjective judgements" is incorrect. These findings were based upon careful construction of a "screen" of key regulatory requirements that are most essential to patient health and safety. This screen was applied to HCFA's own data, in an improved version of a method developed by HCFA itself in 1981. To construct and improve upon HCFA's screen to identify substandard skilled nursing facilities, Committee staff considered and evaluated the following information.

(a) Conferred with GAO and the DHHS OIG to gain their insights on which of the 500+ regulatory requirements are most essential to patient health and safety. GAO surveyed a group dominated by long term care professionals and nursing home operators to see which requirements they would rate most highly. The respondents awarded an average score of 4.24 (on a scale of 5.0) to those items selected by the Committee staff as most closely related to the quality of patient care.

(b) Staff considered and rejected the idea of simply using HCFA's deficiency database, which revealed that over 90% of certified nursing homes violated at least one of the 500+ Federal regulatory requirements for certification, because many facilities would have been guilty only of violations of minor technical rules.

(c) Analyzed HCFA's inspection report database in May 1986, and again six months later, using HCFA's own "critical requirements" list, and found in each analysis that about half of certified SNFs were cited for noncompliance in their last inspection. (Recently, HCFA has altered their list of critical requirements with the result that a smaller number, about 10%, of SNFs appear to violate the critical requirements.)

(d) Studied official inspection reports, with narrative descriptions of incidents cited as nursing home health and safety code violations. Staff review of these hard copy inspection reports began in 1984 and continued through May 1986. Committee staff identified those regulatory code sections, or "tag numbers", actually used by Federally-funded inspectors in the field to cite the most serious violations.

(e) Selected key "element" level requirements for inclusion in the Committee staff list, to improve upon HCFA's critical requirements list. This step was taken to reflect findings of studies by HCFA, the DHHS IG, GAO, and Committee staff that show inspectors in practice often cite serious deficiencies under the least serious applicable category of violation (the "element" level), to avoid having to decertify the facility, and to avoid reprisals for being too aggressive.

HCFA CRITICISM #4.

The HCFA paper further states: "HCFA cannot respond specifically to these allegations at this time since the Committee's data is constructed differently from the HCFA data base, and is outdated."

COMMITTEE STAFF ANALYSIS.

- HCFA states elsewhere in its "response" that the agency did, in fact, duplicate the Committee staff analysis using current data, but makes no mention of the number of violators it found. An appendix entitled "Number of Deficiencies in the Critical Requirements Identified by the Senate Special Committee", listed as Attachment 1 in HCFA's "response", has been deleted from copies provided to the Committee and media.
- Far from being "outdated", the data used by Committee staff are a direct duplicate of HCFA's own current datafile as of November 1985. Committee staff would provide HCFA with HCFA's data tape, but has not been asked for it.
- HCFA describes the Committee staff study of nursing homes' performance patterns as a review of "outdated" data, but the DHHS IG and the GAO concur with Committee staff that HCFA, too, should be using its inspection database to identify facilities with a record of chronically poor performance.

Both the data tapes provided to GAO by HCFA, as well as the computer programs for data analysis, continue to be available and could have been easily used by HCFA to exactly replicate Committee staff analysis; not only for the purpose of verifying the GAO/Committee staff findings, but also for updating the various aggregate data of violations contained in the Committee staff report. HCFA has made no requests to Committee staff for assistance and, therefore, is mistaken in asserting that it "cannot respond" to the Committee's findings.

HCFA's complaint that the Committee's data were "outdated" is puzzling. The Committee's data are simply HCFA's own data, current as of November 1985, when HCFA produced a tape for GAO to use in its work for the Committee. To the extent the November 1985 data were "outdated" at that time, HCFA is well aware of the lengthy delays (as much as a year or more) in the inclusion of inspection data in HCFA's data base. These delays, of course, precluded HCFA from generating facility deficiency profiles reflecting the current year. Nonetheless, Committee staff recognized that such analyses, even with a one-year lag, are valuable in identifying those nursing homes with a consistent history of substandard care, and in finding patterns of nursing home violations.

HCFA CRITICISM #5.

The HCFA paper complains that "committee staff have . . . refused to identify to HCFA which facilities were examined in their 'case studies'."

COMMITTEE STAFF ANALYSIS

o The purpose of the case study profiles, which are based entirely upon inspection reports in HCFA's possession, is to depict historical patterns of poor care that endure despite repeated inspections.

o As HCFA knows from its work during 1984-85 with the Committee, regarding complaints against a chronically substandard skilled nursing facility in western Pennsylvania, when the Committee receives complaints of substandard care being provided at nursing home facilities, allegations are forwarded to HCFA for investigation and action.

o If HCFA believes all chronically substandard facilities should be promptly inspected, the agency can identify hundreds of similar providers by analyzing its own data in the manner advised by the Committee staff, the OIG and GAO.

HCFA has not requested the names of the "case study" facilities. Moreover, HCFA's complaint is surprising in that it has full and immediate access to any and all inspection reports through its 10 regional offices. Instead of being concerned with the four examples contained in the Committee staff report, HCFA should, and could easily, identify through analysis of its own data base the 580 to 740 repeat-offender SNF facilities, as well as the data for ICFs which were not included in the Committee staff report. HCFA could then direct its regional offices to review and analyze the inspection reports for all of these facilities, and determine on a current basis the compliance status for each of them.

HCFA COMPLAINT #6.

The HCFA paper states: "The [Committee staff] report deliberately avoids any discussions with groups or individuals who might have something good to say about Federal/State efforts to enforce nursing home requirements. Even such groups as the National [Citizens'] Coalition for Nursing Home Reform (NCCNHR) and the American Association for Retired Persons (AARP) have been excluded. This is particularly interesting since these groups are the principle consumer representatives and, we believe, have been generally satisfied with our efforts."

COMMITTEE STAFF ANALYSIS

- Committee staff have often met and spoken with representatives of AARP and NCCNHR and other organizations, and find strong agreement with the criticisms of HCFA and recommendations for reform contained in the staff report.
- Undoubtedly these consumer organizations appreciate HCFA's efforts to improve quality care, but are by no means "generally satisfied", either with HCFA's actions to date, or their planned actions with respect to implementation of the IOM recommendations.
- Whatever degree of "satisfaction" exists among private groups cannot obviate the need for congressional oversight of HCFA's execution of its statutory mandate.

Numerous criticisms of HCFA's performance can be found in consumer correspondance and court filings; many of which are reposited in HCFA's own files, and some of which were presented in testimony at the Committee's May 21, 1986 hearing.

HCFA is, or should be, aware that national consumer groups have publicly and repeatedly voiced their dissatisfaction with HCFA's performance. For example: (1) a April 9, 1986 letter to HCFA was cited in the Committee staff report, which was co-signed by over a dozen national organizations (including the NCCNHR and AARP), urged HCFA to implement important corrections in its survey and certification program; and (2) at a recent conference of the NCCNHR, consumer representatives from across the nation charged that HCFA's planning and recent efforts in ensuring quality of care in nursing homes are inadequate.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

NOV 21 1986

Mr. David Schulke, Investigator
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Schulke:

Enclosed is a copy of the Health Care Financing Administration's (HCFA) response to the Staff Report on Nursing Home Care, Senate Special Committee on Aging. As I believe Tom Morford explained to you when you requested the document, this response was prepared for the HCFA Administrator as an analysis of your report, and not as a public response. HCFA has no plans to distribute this document, though it is available if requested.

If we can be of further assistance, please let us know.

Sincerely yours,

Ellen Shillinglaw

Ellen Shillinglaw
Director
Office of Legislation and Policy

Enclosure

cc: Tom Morford

Response to the Senate
Special Committee on Aging
Staff Report on Nursing Home Care

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2. SNFs with Conditions of Participation Out of Compliance

3. Initiatives to Improve MMACS

EXECUTIVE SUMMARY

- We strongly disagree with the report's conclusion that many nursing homes are egregiously substandard. The American public can be confident that we make every effort to ensure our elderly receive quality care in a safe environment.

- The report concludes that one-third of certified nursing homes are substandard. This conclusion is, at best, based upon indefensible subjective judgments. There is absolutely no reason to believe that this is the state of America's nursing homes. Furthermore, any facility found to be substandard is vigorously forced either to correct the problem or face termination from Medicare and/or Medicaid.

- The report concludes that there are 582 (7%) "chronically deficient" SNFs because they are "in violation of at least three critical conditions..." Our data indicate that there are no SNFs deficient in these three conditions.

- The report further alleges that in 1984, 3036 (34%) of certified SNFs failed to comply with "the most essential" of the many Federal health, safety, and quality standards, and that 100 (11%) of these SNFs were cited for violating three or more "critical minimum standards." HCFA cannot respond specifically to these allegations at this time since the Committee's data is constructed differently from the HCFA data base, and is outdated. However, we completed an analysis of current data on both the committee's critical requirement list and our own list of critical requirements. This analysis revealed that:

  - Using the committee list, 61% of all deficiencies cited on initial survey had been corrected prior to certification and 38% had an approved plan of correction, accounting for 99% of all critical deficiencies.

  - Using the HCFA list, 64% of deficiencies were corrected and 35% had an acceptable plan of correction, again accounting for 99% of identified critical deficiencies.

  - Data in the report are obsolete since they are from 1982-1984. While HCFA is conducting its own analysis using current data, it is difficult to replicate whatever the committee staff used in reaching its conclusions.

- The report fails to mention the wide range of enforcement efforts States take under their licensure laws in concert with Federal regional offices to deal with substandard facilities. These efforts include fines, State receivership, and other civil and criminal penalties.

By ignoring the excellent Federal/State enforcement records, as well as the hard work of consumer advocates and a majority of the nursing home industry, the report does the nation's elderly a major disservice. By presenting such an inaccurate view, it unjustly erodes their confidence in a system which is working to assure Americans that they can have confidence in the quality of the care they will receive in certified nursing homes.

- The committee staff have so far refused to identify to HCFA which facilities were examined in their "case studies." When we receive a complaint or other information about problems in a facility, we react immediately to investigate. By refusing to identify the facilities cited, committee staff have, in effect, hindered any corrective action we might take and, frankly, subjected these "studies" to some skepticism.

- Committee staff never discussed the report with program management in an effort to understand more fully the data or issues they were analyzing. This contributes to some of the fundamental flaws in the analysis and conclusions.

- The report deliberately avoids any discussions with groups or individuals who might have something good to say about Federal/State efforts to enforce nursing home requirements. Even such groups as the National Coalition for Nursing Home Reform and the American Association of Retired Persons have been excluded. This is particularly interesting since these groups are the principle consumer representatives and, we believe, have been generally satisfied with our efforts.

- The report neglects to even discuss the many initiatives HCFA and the states have taken to ensure quality care for our nation's nursing homes. In particular, HCFA has taken an extremely aggressive posture over the last 3 years which the report neglects to mention:

    - Issued new termination procedures to State agencies. These procedures streamline the process to terminate a facility from Medicare.

    - Issued "Look-Behind" procedures to Federal staff. In cases where the State has not performed its survey responsibilities properly, these procedures enable the Federal government to move quickly against a substandard facility--especially when it is endangering patients' lives.

    - Developed a new long term care survey process. The new Patient Care and Services (PaCS) survey process focuses surveyor attention on outcomes--the care status of patients as opposed to just structural and procedural items.

  - Established new agreements with States so that States would understand exactly what they were expected to do in enforcing Federal requirements.

- These initiatives indicate that HCFA shares the Committee staff's desire to assure that care of the highest quality is provided to every Medicare beneficiary and Medicaid recipient in the nation's certified skilled nursing facilities. Substandard care provided to even one elderly patient cannot be tolerated.

- Many of the committee staff's recommendations are similar to those found in the study on the quality of care in nursing homes from the Institute of Medicine. HCFA contracted with the Institute of Medicine to conduct this study, and is currently analyzing the voluminous report which was recently completed at a cost of $1.6 million.

INTRODUCTION

Culminating a 2-year investigation of the state of nursing home care in the United States, the Senate Special Committee on Aging has recently held hearings and released a staff report summarizing its findings. Entitled "Nursing Home Care: The Unfinished Agenda", the report contains a number of specific policy recommendations aimed at improving the quality of care in nursing homes.

We agree that further improvements in the nursing home quality assurance system are desirable and, in fact, have taken action prior to the Committee's report tc implement some of its recommendations. However, we strenuously object to the sensationalistic tone of the report - such as the Committee's characterization of nursing homes as 19th century asylums - and its implied theme that Federal and State quality assurance efforts have not been effective in improving overall quality of care in nursing homes.

We dispute the report's fundamental assertion that "bed, board and abuse" have been allowed to replace proper medical and rehabilitative care in certified facilities. A general consensus exists that, although there is still room for improvement, the past decade has witnessed substantially upgraded conditions in the nation's nursing homes. For example, the Institute of Medicine's (IoM) Committee on Nursing Home Regulation released in February 1986 a comprehensive report aimed at problem identification and solution in nursing home quality assurance. The IoM committee consisted of twenty individuals with substantial and diverse knowledge and experience in the nursing home field; its report was referenced on several occasions by the Committee on Aging's staff report. While acknowledging the continuing problem of instances of substandard care, the IoM report offered a much more balanced perspective:

"Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the Committee and of resident advocacy organizations, is that the disturbing practices that were all too common a decade ago now occur less frequently...." "These observations do not mean either that the picture of American nursing homes is entirely gloomy or that the regulatory efforts of the past decade have been entirely unsuccessful. Today, many institutions consistently deliver excellent care. Good care can be observed in all parts of the country; it exists under widely varying reimbursement systems and all types of ownership...." "Nursing homes were essentially unregulated in most States prior to the late 1960s... and the quality of care was appalling...."

"There is consensus that regulations have made a positive contribution, although reliable comparative data are not available to support this judgment. The committee found that the consumer advocates, providers,

and State regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974. But there is substantial room for improvement."
The evenhandedness of the IoM report, prepared by a bipartisan group of acknowledged experts, stands in sharp contrast to that of the Special Committee on Aging.

We also believe that the Committee's report tends to rely on selective and often incomplete data interpretation in support of pre-established premises. This paper examines several of the report's fundamental flaws, notably the lack of attention to or understanding of the deficiency correction methodology and reporting system, and the overreliance on the "critical requirement" concept for assessing the severity of identified deficiencies. In addition, the report purports to "establish the depth and severity of persistently dangerous and unhealthful conditions" for 15,000 nursing homes via four unidentified case studies that constitute a full third of its findings.

The report's basic conclusion is that "tens of thousands of patients" are living in "squalid conditions" in nursing homes that "resemble 19th century asylums". We believe that this is an unfortunate misrepresentation of the overall quality of nursing home care in this country. By undermining public confidence that quality care in a safe environment is available, the report does a grave disservice to ill and elderly Americans and their families as well as to the vast majority of the nation's nursing homes. The Committee's conclusions were apparently drawn using data independently obtained from the HCFA database, the Medicare/Medicaid Automated Certification System (MMACS). The information in the report was never discussed with HCFA program management in an effort to more fully understand the data or issues being analyzed. Instead, the Committee went to third party sources (i.e., GAO and the Inspector General of HHS) who merely accessed the data system. Consequently, the information presented is distorted, misleading, and, at best, outdated by 2 - 4 years, contributing to some of the fundamental flaws in the analyses and conclusions. Because we do not know the methods used by the Committee staff to collect and analyze the data, we have been unable to replicate it. We can, however, based on our knowledge of the survey and certification process and our current data statistics, refute many of the committee report's conclusions.

We are committed to working with the States, the nursing home industry and consumer advocates to pursue continued improvements in nursing home quality of care. However, we believe that Federal certification of a facility is today a reliable indication of acceptable quality care.

RESPONSE TO SPECIFIC ISSUES

The following are our specific reactions to the major issues in the report:

- "Tens of thousands of patients in nursing homes still suffer from the poor nutrition, inadequate nursing care and squalid conditions thought to have been corrected long ago by State and Federal reforms."

  The above statement was presented as Problem #1 in the body of the Report. To support this general conclusion that many nursing homes are grossly substandard, the committee devoted one-third (16 pages) of the report to 4 case studies alleged to be representative of some 15,000 long term care facilities. Because the identity of these facilities was not disclosed in the report, we contacted the committee for the names of the four nursing homes in order to investigate, first hand, the conditions of the facilities and, if necessary, take corrective action as soon as possible.

  However, the staff refused to furnish the information, preventing us from validating the data and taking corrective action if appropriate. This unwillingness on the part of the committee staff to assist us in investigating these facilities that are allegedly providing "grossly inadequate care resulting in humiliation, suffering and premature death" raises serious questions regarding the actual intent of the report and the validity of the data.

- "...there has been a dramatic increase in violations of major conditions.... Despite the high numbers of violations, the federal government decertified about 200 nursing homes in 1985, with most choosing voluntarily to close."

  As a basis for making this sweeping statement, the Committee attached a chart containing nine statements identified as "critical standards and requirements for minimally acceptable nursing home care." Accompanying the statements are some figures dating back to 1982 and 1984 showing the number of violations of each "requirement" for each year along with a percentage of increase. The report's interpretations of these requirements constitute deliberate distortions of the actual Federal requirements. In addition, the simplistic comparisons of aggregate deficiency data from different years are equally misleading.

  For example, from a list of "key" requirements, which the committee personally compiled, they cite the following as a key standard for measuring minimally acceptable care:

  > "(F70) Element: Patient is transferred or discharged for legitimate reasons (medical, welfare of other patients) and is given reasonable advance notice."

The Committee's chart inverts and embellishes this statement to read:

> "Patient discharged or evicted from facility without legitimate reason.

The actual requirement as it reads on the Federal survey form is as follows:

> (F70) Is transferred or discharged only for medical reasons, or for his or her welfare or that of other patients, or for nonpayment for his or her stay (except as prohibited by Titles XVIII or XIX of the Social Security Act) and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in the medical records.

(The underlined portions were arbitrarily omitted from the Committee's version of this requirement.)

F70 is the computer data tag for that requirement which will show up as deficient in the Medicare/Medicaid Automated Certification System (MMACS). This requirement could be easily marked deficient during a survey, although a transfer of the resident was properly performed. Documentation in the medical record could have been unclear, misplaced, or sitting on someone's desk, but because it was not there at the time of the review, the surveyor would cite the element deficient. Using MMACS data as the committee used it, this deficiency (i.e., F70 in MMACS) would have been translated by the committee as "patient discharged or evicted from facility without legitimate reason." The other eight "standards" in the Committee's chart were reinterpreted in a similar fashion, distorting the intent of the underlying requirements and the overall picture of nursing home care.

Even if the standards were properly stated and the outdated figures verifiable, the aggregate deficiency comparisons presented in the accompanying charts in no way constitute legitimate evidence of deterioration in nursing home care. The report makes no mention of a number of legitimate reasons for increases in deficiency citation including the addition of almost 1000 new facilities, and 100,000 beds since 1982, and the restoration of full certification funding for long-term care facility surveys after 1982, representing a 60% increase over 1981 and 1982.

- Terminations

The committee produced a chart indicating the number of involuntary terminations that occurred in skilled nursing facilities between 1980 and 1985. The results of our data analysis differ considerably from the committee's findings. Following is a comparison of the Committee's figures on involuntary SNF terminations with ours:

	1980	1981	1982	1983	1984	1985	1986 (as of 5/86)
Committee Figures	45	26	10	7	11	3	Not available
HCFA Figures	56	32	20	10	27	28	14

The report also indicates that only about 200 long term care facilities (i.e. SNFs, ICFs, and ICFs/MR) were decertified in 1985, with most choosing voluntarily to close. In actuality, 296 facilities were decertified in 1985. Facilities will often choose to terminate voluntarily rather than be involuntarily terminated and will do so before involuntary termination procedures are completed.

o "... in 1984 over one-third of the nation's certified nursing homes failed to fully comply with the most essential health, safety, and quality standards of the Federal government.... the Committee staff estimate is conservative because the Federal database underreports the extent of substandard care being provided in nursing homes.

To arrive at these misleading conclusions, the Committee, in concert with GAO and the Inspector General of HHS, drew up a list of their own "critical" health and safety standards (what they felt to be most directly related to patient well-being.) Presumably, if a facility was not in compliance at the time of survey with one or more of the Committee's designated critical requirements, that facility was listed as failing to "fully comply with the most essential health, safety, and quality standards of the Federal government." Disregarding the fact that only 7 of the Committee's 25 key requirements are on our own critical requirement list, there are a number of additional reasons why such a conclusion is seriously misleading.

Throughout the report, in its analysis of cited deficiencies, the committee fails to mention whether any of these deficiencies were corrected, or had an acceptable plan of correction prior to certification. The correction procedure is an integral part of the survey and certification process and a key consideration in determining the condition of our nursing homes and whether HCFA is properly performing its function of assuring quality care.

Because 1984 data is unavailable, we did a current analysis using the committee's own list of critical requirements. Of all the deficiencies cited at the time of survey, 61% were subsequently corrected and 38% have an acceptable plan of correction which accounts for 99% of all the "critical" deficiencies cited (see Attachment 1). We did a similar analysis on our own list of critical requirements and found that 64% had been corrected and 35% had an acceptable plan of correction, again accounting for 99% of all critical deficiencies cited. Also, the committee's report fails to point out that if surveyors find problems sufficiently serious to endanger patients, they are instructed to either have the facility resolve the problem immediately or begin termination action. We know that the vast majority of deficiencies cited at the time of survey are either corrected or have an acceptable plan of correction at the time of certification.

We recently did some analysis on all Conditions of Participation that were being reflected in MMACS as out of compliance. Based on a regional review of the actual case files, we found that only a small fraction of the number reflected in the system was actually of out compliance. The biggest problem in most regions was getting the revisit reports (which contain deficiency correction data) entered into MMACS on a timely basis.

This data entry problem is due in a large part to heavy workloads. Entry of revisit reports has traditionally been viewed as "paper" (record) correction and as such is usually assigned a lower priority than, for example, entering (re)certifications which affect facility reimbursement, or other functions that are more directly related to the health and safety of patients. Thus, rather than underreporting the extent of substandard care, as the committee alleges, the database actually overreports existing problems.

Another major omission from the report is any explanation of how a deficiency is cited and exactly what the citation means. The committee's specific selection criteria or rationale for its 25 designated critical requirements was not disclosed in the report other than to say they felt these to be most directly related to patient well-being. Fifteen of those 25 requirements were at the element level. For SNFs, there are 328 elements making up 84 standards comprising 18 conditions. The element is by definition the least serious type of deficiency, used by surveyors to point out specific minor infractions that could, in the aggregate, eventually lead to care problems. It is only after reviewing citations at the element level that the surveyor is able to evaluate the degree of non-compliance and make a judgment regarding the facility's compliance with the related standard or condition which, if cited as deficient, would indicate a more serious problem in that area. The surveyor would then consider the degree of compliance of related standards to determine whether the pertinent condition overall was met or not met.

For example, there could be 1,000 cited deficiencies in what the committee considered a critical element. However, the majority of those citations may be for very minor infractions which a conscientious and well-trained surveyor would cite but which would in no way affect the compliance status of the related standard or condition.

One of the elements the committee identified as key or critical deals with rehabilitative nursing care and reads as follows:

> Rehabilitative nursing care services are performed daily for those patients who require it, and are recorded routinely (F176).

A surveyor could enter the facility and determine that rehabilitative nursing care services are performed daily on patients requiring them, but because a nurse, on a particular occasion simply failed to record the service, the surveyor would cite the omission at the element level. For the Committee's purposes, that facility would be considered in violation of a critical requirement for minimally acceptable nursing home care when, in fact, rehabilitative nursing care services are intact and appropriate.

Because the committee's list of "critical" requirements, with 60% at the element level, is not an accurate gauge for measuring "minimally acceptable nursing home care," we performed our own analysis on the requirements that by regulation measure minimally acceptable care--the Conditions themselves.

- Analysis of Conditions of Participation

  Although there were only three conditions cited on the committee's list of critical requirements--Governing Body (F15), Physician Services (F101), and Nursing Services (F123), our analysis encompassed all 18 SNF conditions. The results of that analysis (see Attachment 2) indicate that 89% of the COPs out of compliance at the time of survey were corrected, and the corrections were processed to MMACS. Of the remaining 11%, most were corrected, but not yet reflected in MMACS due to delays in data entry.

- Problems with MMACS

  In its report, the committee frequently alludes to the lag time in having recent survey data reflected in MMACS and indicates that HCFA does not use the system to monitor nursing homes or State survey agencies. However, since 1984, we have developed several initiatives to improve the timeliness and accuracy of the information in the MMACS database and to step up the use of MMACS as a monitoring tool. These initiatives are discussed in detail in Attachment 3.

COMMITTEE RECOMMENDATIONS

The committee concludes their report with a list of staff recommendations. In its zeal to identify shortcomings in the enforcement of program requirements by HCFA and the States, the committee has failed to recognize the efforts taken in recent years to upgrade the overall quality of care being furnished program beneficiaries, including two of the most publicized changes in the history of the certification program--the new resident centered and outcome-oriented inspection process in nursing homes and new, streamlined termination procedures. Also ignored have been the efforts to involve all affected groups in the policy-making process. Although an "open" process consumes more time, the policies emanating reflect the reality of the needs and demands of the States, consumers, and the health industry.

Following are the Staff Recommendations and a synopsis of what we have developed and/or implemented in each of these areas:

- Strengthen the nursing home inspection system

  Within the last two years, the enforcement process has been considerably strengthened and other initiatives under development will strengthen it further.

  1. In December, 1985, after almost two years of meetings, proposals, and counter-proposals, the procedures for terminating Medicare participation were revised. Existing procedures were replaced with a more streamlined process developed around processing time limits. We developed a tracking system to monitor regional office and State agency adherence to the procedures. The new procedures not only require an accelerated process (23 days) following a determination that a facility's deficiencies pose an immediate and serious threat to patient health and safety, but almost as importantly, they balance the rights of the beneficiaries, the providers, and the Government to ensure that all parties receive the full measure of the protections afforded by the Social Security Act.

  2. We strengthened the procedures for implementing the Secretary's authority to "look behind" Medicaid determinations. We revised procedures to provide a more uniform approach to the application of this authority. These new procedures enable HCFA to take quick and decisive action when Federal look behind surveys countermand State findings.

  3. We completed the updating of our program manuals for the State agencies and HCFA regional offices. Up-to-date instructions assure a more uniform and consistent interpretation, application, and enforcement of program requirements.

4. We revised the contract executed between the Secretary and the States that specifies the survey and certification functions of the Medicare State survey agency. This contract, which had not been revised since the early 1970s, is referred to as the Section 1864 Agreement. The revised Agreement is not only explicit in delineating survey agency responsibilities, but it now enables the Secretary to terminate all or part of the Agreement if the Secretary finds that the survey agency is not meeting its survey and certification responsibility.

5. The role of the surveyor was clarified by the issuance of a policy statement emphasizing that the primary role of the surveyor is to apply and enforce program requirements rather than act in a consultative capacity in assisting facilities to correct deficiencies. Surveyor efforts to provide assistance to facilities led some providers to believe that it is in the government's role to assist the providers in achieving and maintaining compliance. The new policy clarifies that the government's job is to determine what problems exist and to identify those problems (deficiencies). Developing appropriate plans of correction and achieving corrections, as promised, is the responsibility of the providers.

6. Throughout 1985 and into 1986 training efforts were increased. Regional office and State agency staff were trained in the new long term care survey process and termination procedures. Staff also received training designed to enhance current skills. Over half of the surveyors received nationally sponsored training.

7. The survey method for determining whether or not a skilled nursing or intermediate care facility meets program participation requirements has been revised. The new survey process is resident centered and outcome-oriented and assesses facility compliance by evaluating the quality of care and services actually being furnished to residents. The process was developed and tested over several years and will be implemented beginning in July 1986.

o Mandate improved State response to consumer complaints and requests for inspection and cost reports

A process that will enable the timely processing, investigation and resolution of complaints is under development. Complaints represent a relatively untapped resource of information on the quality of care and services being furnished. Complaint data will be used as an integral ingredient in the enforcement process since it provides information on facility compliance during the interval between onsite surveys. In creating an effective system, we must however make it compatible with complaint systems already in place in the States.

- Authorize a full array of "intermediate sanction" penalties and receivership authority, so a measured incremented enforcement approach can be taken by inspectors, and substandard homes can be improved without relocating all the residents of these facilities.

  This year we will implement a ban on new admissions as an alternative to termination if deficiencies do not immediately jeopardize patient health and safety. The ban will be used for providers who have demonstrated, historically, the ability to correct cited deficiencies. This provision will reduce the need for termination and the consequent need for patient relocation.

- Elevate "resident rights" to a condition of participation and strengthen these rights.

  The proposal to change the current Conditions of Participation by elevating Resident Rights from a Standard to a Condition of Participation is under active consideration by HCFA. This change may increase the significance of deficient findings. In effect, this action will strengthen resident rights since facilities which violate resident rights will be more likely to jeopardize their continuing status in the program. This will not provide "new" rights since all constitutional and legal rights are maintained while residents are in nursing homes, and these guarantees are protected by means other than a new regulation. However, rights requirements in this proposal emphasize that residents do not give up any rights while confined to a nursing home. Finally, in concert with this perspective, the rights statement can be expanded to emphasize residents rights to self-determination and choice. It may also be necessary to accentuate these rights by restating them and identifying the facility's responsibilities for maintaining these rights elsewhere in requirements.

- HCFA should issue instructions to the State agencies and HCFA regional offices, informing them of their obligation to enforce existing laws, such as (1) penalties for repeat offenders; and (2) prohibitions against Medicaid discrimination.

  1. This proposal corresponds with the IoM study's recommendation that we take action against providers who are cited year after year for repeat deficiencies. Prior to receipt of the IoM, we had developed our own proposal for dealing with providers - all providers not just long term care facilities - who have demonstrated the unwillingness or inability to maintain compliance. Our proposal, if implemented as a regulation, will enable us not only to terminate participation for the repeated failure to meet the same or different requirements in successive years, but it will bar readmission to the program for specified periods of time.

2. In concert with the Under Secretary's Task Force, HCFA is analyzing the full range of issues relating to Medicare discrimination, including the scope of the problem and related administrative and legislative issues.

o HCFA should expand the hospital swing-bed program, to (1) ease the tight bed supply situation that facilitates illegal discriminatory practices; (2) increase competition in the industry, so quality can be more of a factor in the marketplace.

The Rural Swing-Bed Program was congressionally mandated by the Omnibus Reconciliation Act of 1980. The legislation permits hospitals with fewer than 50 beds that are located in rural areas with a shortage of long term care beds to "swing" their beds between acute and long term care as needed. The program is to extend from September 1983 to November 1987. An evaluation of the project will assess the impact on:

+ Access to long-term care beds in rural areas
+ Quality of long-term care in hospitals
+ Cost of services in swing-bed hospitals
+ Program-wide costs
+ Administrative costs to administer and monitor the program.

Based on the findings and recommendations, Congress will decide whether to continue the program or extend it to larger hospitals. The first evaluation report is expected in late 1986.

Attachment 1

Number of Deficiencies in the Critical Requirements Identified by the Senate Special Committee on Aging

C	S	E *		1986 to Date	Corrected	Acceptable Plan of Correction
X			F15 Governing Body	145	132	1/
	X		F62 Patients Rights	96	64	31
		X	F70 Orderly Transfer or Discharge	74	52	22
		X	F71 Encouraged to Exercise Rights	55	35	19
		X	F73 Free from Mental & Physical Abuse	861	559	296
X			F101 Physician Services	25	21	1/
	X		F105 Patient Supervision by Physician	101	63	35
		X	F111 Total Care Reviewed	665	379	270
		X	F112 Signs Orders and Progress Notes	803	430	348
X			F123 Nursing Services	232	208	1/
	X		F134 24-Hour Nursing Services	518	360	153
		X	F135 Nursing Service Meets Needs	1012	623	378
		X	F136 Proper Care	2867	1647	1196
	X		F173 Rehabilitative Nursing Care	429	260	162
		X	F175 Active Program of Rehabilitative Care	1140	581	548

1/ A plan of correction is not acceptable for a Condition of Participation.

* C - Condition S - Standard E - Element

Attachment 1 (cont'd)

Number of Deficiencies in the Critical Requirements Identified by the Senate Special Committee on Aging

C	S	E*		1986 to Date	Corrected	Acceptable Plan of Correction
		X	F176 Rehabilitative Nursing Performed Daily	1366	768	579
	X		F177 Supervision of Patient Nutrition	349	236	108
		X	F178 Awareness of Nutritional Needs	1173	719	438
		X	F180 Patient Intake Deviations Noted	1144	641	495
	X		F181 Administration of Drugs Noted	128	89	38
		X	F182 Drugs Administered by Qualified Staff	142	108	32
		X	F186 Dosage Properly Recorded	1214	740	446
	X		F189 Conformance with Physician Drug Orders	225	161	61
		X	F190 Administered in Accordance with Written Orders	1836	1180	628
		X	F191 Automatic Stop Order	333	214	112
				(100%)	(61%)	(38%)
					(99%)	

Attachment 2

SNFS With Conditions of Participation Out of Compliance

	SNFs With COPS Out of Compliance at the Time of Survey 1/	CoPS Corrected 2/	CoPS Uncorrected3/
F7 Compliance with Federal, State, and local laws	61	51	10
F15 Governing Body and Management	138	124	14
F90 Medical Direction	42	38	4
F101 Physician Services	22	18	4
F123 Nursing Services	229	205	24
F207 Dietetic Services	101	92	9
F249 Specialized Rehabilitative Services	61	50	11
F263 Pharmaceutical Services	48	46	2
F286 Laboratory and Radiologic Services	13	12	1
F300 Dental Services	17	15	2
F308 Social Services	48	37	11
F324 Patient Activities	59	52	7
F335 Medical Records	33	32	1
F359 Transfer Agreement	3	3	0
F366 Physical Environment	53	45	8
F428 Infection Control	120	109	11
F448 Disaster Preparedness	23	19	4
F462 Utilization Review	44	43	1
	*627/1115**	2/ *542/991**	*85/124**

1/ Based on the most current SNF survey record in MMACS data file as of May 31, 1986.

2/ This column represents the SNFs with CoPs out of compliance that have had corrections processed to MMACS.

3/ This column represents those SNFs with CoPs out of compliance that have not had corrections processed to MMACS.

*SNFs with 1 or more CoPs out of compliance.
**Total number of CoPs out of compliance.

Attachment 3

Initiatives to Improve MMACS

- Front End Data Entry

  In March 1985, we made an important change in how certification kits are processed in the regional offices. Regions are now required to enter all recertifications into MMACS upon receipt in the regional offices prior to review by certification specialists. This process is called "front-end data entry". Computer-based flags automatically screen recertification cases for critical requirements, including Conditions of Participation. Cases failing the screen are subjected to indepth professional review. Cases passing the screen require no professional review after entry into MMACS. Because the cases are being entered into MMACS as soon as they are received in the ROs, the lag time in entering certifications has been significantly reduced.

- Case Control System

  In conjunction with the "front-end data entry process", we developed a standardized MMACS-based case control system in September 1985. This system provides central and regional office management with important information for monitoring certification activity and identifying processing bottlenecks. In addition to providing summary data on the number of recertification cases that are received, cleared, pending, and pending over 30 days in the regional offices, the case control reports also identify cases that are due from the States. This enables the regions to identify any recertification cases that have not been forwarded by the States within prescribed timeframes.

- SA Direct Data Entry

  Delays can occur from the time the survey takes place to when the results are forwarded to the regional offices for review and data entry. To eliminate unnecessary paperflow and facilitate timely data entry, we began a pilot project in 1984 in four States to test the feasibility of transferring the responsibility for data entry from the regions to the States. The demonstration has been successful and we plan to increase the number of participating States this year. We expect that all States will be entering the data directly into MMACS within two years.

Attachment 3 (cont'd)

- Adverse Action Extract, HCFA-462

  Recently, we developed a new form (HCFA-462) to ensure the prompt processing of certification actions where there is the potential for adverse action (terminations and denials of payments for new admissions (alternative sanctions)). The pertinent information from the form will be entered into MMACS, and based on our analyses of the data, if the State agencies or regional offices fail to process these actions in accordance with manualized processing time limits, their failure will be documented and brought to their attention for corrective action during the State and RO evaluation programs.

- Federal Monitoring Survey System (FMS)

  The FMS system, a subsystem of MMACS, was recently revamped in order to provide central and regional offices with essential information from direct Federal surveys. The data from this system will assist in:

  - assessing the overall effectiveness of the State survey program;
  - analyzing the effects of national survey policies/procedures;
  - monitoring problem providers; and
  - performing regional comparisons to see if Federal guidelines are being applied uniformly.

  The FMS system was designed to analyze the results of the direct surveys conducted by the regional offices, automatically comparing their findings with State conducted surveys.

- Survey and Certification Operations Report (SCOR)

  In July, 1985 we issued the first in a continuing series of quarterly reports to the Regional Administrators and top level HCFA management on certification activities in the ROs. The SCOR focuses on various aspects of certification activity each quarter using MMACS as its primary data source. Through the SCOR we have been alerting the regional offices to excessive processing times, processing bottlenecks, deficiency trends, improper processing and/or certification procedures, etc. When significant problems are uncovered through analysis of SCOR (i.e. MMACS data), followup memoranda are sent to the ROs outlining the problem and recommending specific actions to be taken.

Attachment 3 (cont'd)

- Future MMACS Enhancements
  - Over the next few years, we plan to expand and upgrade the MMACS to be a more effective and efficient state-of-the-art management information system. Our plans include modifying the data base to capture more patient specific information and less statistical and deficiency related information. We will focus our attention on outcomes of patient care rather than on facility compliance with the traditional structure and process requirements.
  - Another way we plan to enhance the data system is to streamline the data collection and entry techniques. As mentioned previously, within two years we expect all the States to be entering the survey results directly into the data base instead of forwarding the hard copies to the regional offices for review and data entry.
  - This year we plan to use data from MMACS, almost exclusively, to evaluate our regional offices' performance. We also have plans to computerize the State agency review process.

MEMORANDUM -- FYI

December 8, 1986

TO: Stephen McConnell, Staff Director

FM: David Schulke, Investigator
James Michie, Chief Investigator

RE: HCFA Release of Unabridged "Response" to Nursing Home Report.

Three weeks after our original request, HCFA has provided Committee staff with a complete copy of their paper which attempts to rebut the findings of the May 1986 Committee staff report, "Nursing Home Care: The Unfinished Agenda". The unabridged document reveals that pertinent information, contained in two attachments, was omitted from copies of this paper previously provided to this Committee and to members of the press.

The omitted data reveal that serious violations do occur with alarming frequency. The attachments replicate and confirm the key findings of the Committee staff report and specifically contradict the posture adopted by HCFA in the body of their paper, where it is stated "[w]e strongly disagree with the report's contention that many nursing homes are egregiously substandard". Moreover, these data reveal the Committee staff assessment of 1984 inspection data is also true of conditions discovered in nursing homes during 1986. This finding is consistent with our recent discovery that in 1986 about half of all SNFs violate one or more of HCFA's own list of "critical" health and safety requirements.

The missing attachments are integral to assessing HCFA's contention that nursing home care is really better than the inspection data indicate. HCFA developed the data in the omitted attachments to support its contention that, because nursing homes must eventually show they have "corrected" their deficiencies, it is unfair and even "sensationalistic" to dwell on the extent and nature of their violations. While the data are valuable, we believe this argument diverts attention from the illegal conduct of providers who, in making required corrections, do no more than simply agree to comply with the law after they've been cited for violations. HCFA's reliance upon their records of provider "corrections" is flawed because: (1) verification of provider "corrections" often resembles a dress rehearsal, performed for the benefit of inspectors during an anticipated follow-up "revisit"; (2) short-lived or fallacious "corrections" can be logged into the inspection report database as actual corrections; and (3) even when genuine corrections are made in response to cited violations, such corrections cannot excuse or mitigate the fact that, at any given time, thousands of nursing homes fail to comply with the most important Federal minimum standards.

APPENDIX 3

DATA AND DOCUMENTATION RELATING TO THE EXTENT OF SUBSTANDARD NURSING HOME CARE

[**COMMITTEE STAFF NOTE:** The following print out displays the number and percentage of certified Skilled Nursing Facilities (SNFs) found to have violated HCFA's list of Critical Requirements (CRs) during the most recent inspection on file in HCFA's automated MMACS database as of May 1986. (For a listing of CRs applicable in May 1986, please see February 18, 1986 Request for Services memorandum in the DHHS internal documents appendix.)

To read the print out: Inspection findings are presented state by state within each federal region. State identification numbers appear in the first column on the left side of the print out. The second column shows the total number of SNF certified facilities in the State. The fourth column shows the number of SNF certified facilities that violated none of HCFA's CRs, followed in the fifth column by the percentage of SNFs in the State that violated none of the CRs, by State. Each additional pair of columns to the right illustrates the number and percentage of SNF certified facilities found in violation of one, two, three (et seq.) CRs on their most recent inspection Regional subtotals appear after figures for individual States within each region. National totals appear on the second page of the print out, at the base of each column.

For example, the number of facilities found fully in compliance with HCFA's CRs in Region 1 is 211, or 33.49%, out of a total of 630 SNF certified nursing homes in the region. Nationally, the number to fully comply with HCFA's Critical Requirements was 4,042 of 8,991 facilities, or about 45%.

The next several pages of print outs represent an updated analysis of the most recent inspection on file in MMACS as of November, 1986. These print outs contain the same information as that described in the first print out, but arranged so that nursing homes with zero violations appear on one page, facilities with one violation on the next page, and so on.]

snf only critical

State	# Facilities snf	#	%	# of Deficiencies 1	%	2	%	3	%	4	%	5	%	>5	%
0107	197	19	9.64%	64	32.49%	54	27.41%	28	14.21%	20	10.15%	7	3.55%	5	2.54%
0120	18	13	72.22%	5	27.78%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
0122	307	113	36.81%	103	33.55%	34	11.07%	28	9.12%	16	5.21%	4	1.30%	9	2.93%
0130	22	14	63.64%	7	31.82%	0	0.00%	1	4.55%	0	0.00%	0	0.00%	0	0.00%
0141	66	44	66.67%	19	28.79%	2	3.03%	1	1.52%	0	0.00%	0	0.00%	0	0.00%
0147	20	8	40.00%	6	30.00%	4	20.00%	2	10.00%	0	0.00%	0	0.00%	0	0.00%
01	630	211	33.49%	204	32.38%	94	14.92%	60	9.52%	36	5.71%	11	1.75%	14	2.22%
0231	251	90	35.86%	75	29.88%	41	16.33%	18	7.17%	6	2.39%	14	5.58%	7	2.79%
0233	562	276	49.11%	167	29.72%	48	8.54%	30	5.34%	13	2.31%	7	1.25%	21	3.74%
0240	5	1	20.00%	2	40.00%	0	0.00%	1	20.00%	0	0.00%	0	0.00%	1	20.00%
02	818	367	44.87%	244	29.83%	89	10.88%	49	5.99%	19	2.32%	21	2.57%	29	3.55%
0308	27	14	51.85%	8	29.63%	3	11.11%	1	3.70%	1	3.70%	0	0.00%	0	0.00%
0309	6	2	33.33%	1	16.67%	1	16.67%	0	0.00%	1	16.67%	0	0.00%	1	16.67%
0321	114	35	30.70%	34	29.82%	26	22.81%	8	7.02%	6	5.26%	3	2.63%	2	1.75%
0339	583	295	50.60%	209	35.85%	46	7.89%	14	2.40%	11	1.89%	4	0.69%	4	0.69%
0349	83	50	60.24%	22	26.51%	7	8.43%	4	4.82%	0	0.00%	0	0.00%	0	0.00%
0351	40	12	30.00%	13	32.50%	10	25.00%	3	7.50%	1	2.50%	0	0.00%	1	2.50%
03	853	408	47.83%	287	33.65%	93	10.90%	30	3.52%	20	2.34%	7	0.82%	8	0.94%
0401	193	52	26.94%	61	31.61%	35	18.13%	27	13.99%	14	7.25%	1	0.52%	3	1.55%
0410	427	301	70.49%	81	18.97%	30	7.03%	11	2.58%	1	0.23%	1	0.23%	2	0.47%
0411	[illegible]3	98	34.63%	88	31.10%	42	14.84%	23	8.13%	12	4.24%	8	2.83%	12	4.24%
0418	94	67	71.28%	18	19.15%	2	2.13%	4	4.26%	1	1.06%	2	2.13%	0	0.00%
0425	134	41	30.60%	40	29.85%	19	14.18%	16	11.94%	7	5.22%	10	7.46%	1	0.75%
0434	178	84	47.19%	56	31.46%	21	11.80%	11	6.18%	2	1.12%	2	1.12%	2	1.12%
0442	103	59	57.28%	22	21.36%	14	13.59%	5	4.85%	2	1.94%	1	0.97%	0	0.00%
0444	87	38	43.68%	29	33.33%	12	13.79%	4	4.60%	1	1.15%	1	1.15%	2	2.30%
04	1499	740	49.37%	395	26.35%	175	11.67%	101	6.74%	40	2.67%	26	1.73%	22	1.47%
0514	470	214	45.53%	161	34.26%	56	11.91%	19	4.04%	15	3.19%	5	1.06%	0	0.00%
0515	202	61	30.20%	57	28.22%	41	20.30%	21	10.40%	11	5.45%	7	3.47%	4	1.98%
0523	300	231	77.00%	57	19.00%	8	2.67%	2	0.67%	2	0.67%	0	0.00%	0	0.00%
0524	373	262	70.24%	77	20.64%	16	4.29%	11	2.95%	5	1.34%	0	0.00%	2	0.54%
0536	454	139	30.62%	131	28.85%	80	17.62%	43	9.47%	24	5.29%	21	4.63%	16	3.52%
0552	387	169	43.67%	163	42.12%	38	9.82%	13	3.36%	2	0.52%	2	0.52%	0	0.00%
05	2186	1076	49.22%	646	29.55%	239	10.93%	109	4.99%	59	2.70%	35	1.60%	22	1.01%
0604	155	43	27.74%	44	28.39%	32	20.65%	17	10.97%	10	6.45%	2	1.29%	7	4.52%
0619	37	20	54.05%	10	27.03%	4	10.81%	1	2.70%	2	5.41%	0	0.00%	0	0.00%
0632	16	8	50.00%	6	37.50%	1	6.25%	0	0.00%	1	6.25%	0	0.00%	0	0.00%
0637	17	9	52.94%	5	29.41%	1	5.88%	0	0.00%	1	5.88%	1	5.88%	0	0.00%
0645	269	189	70.26%	46	17.10%	19	7.06%	6	2.23%	2	0.74%	5	1.86%	2	0.74%
06	494	269	54.45%	111	22.47%	57	11.54%	24	4.86%	16	3.24%	8	1.62%	9	1.82%
0716	40	16	40.00%	14	35.00%	3	7.50%	5	12.50%	2	5.00%	0	0.00%	0	0.00%
0717	72	12	16.67%	32	44.44%	6	8.33%	11	15.28%	5	6.94%	1	1.39%	5	6.94%
0726	243	111	45.68%	59	24.28%	35	14.40%	21	8.64%	10	4.12%	4	1.65%	3	1.23%

0728	42	21	50.00%	9	21.43%	7	16.67%	2	4.76%	1	2.38%	0	0.00%	2	4.76%
07	397	160	40.30%	114	28.72%	51	12.85%	39	9.82%	18	4.53%	5	1.26%	10	2.52%
0806	164	84	51.22%	46	28.05%	18	10.98%	6	3.66%	4	2.44%	3	1.83%	3	1.83%
0827	85	28	32.94%	30	35.29%	11	12.94%	10	11.76%	1	1.18%	3	3.53%	2	2.35%
0835	59	41	69.49%	13	22.03%	2	3.39%	2	3.39%	1	1.69%	0	0.00%	0	0.00%
0843	68	33	48.53%	22	32.35%	7	10.29%	5	7.35%	1	1.47%	0	0.00%	0	0.00%
0846	45	12	26.67%	12	26.67%	6	13.33%	6	13.33%	5	11.11%	2	4.44%	2	4.44%
0853	23	5	21.74%	7	30.43%	6	26.09%	2	8.70%	1	4.35%	2	8.70%	0	0.00%
08	444	203	45.72%	130	29.28%	50	11.26%	31	6.98%	13	2.93%	10	2.25%	7	1.58%
0903	61	30	49.18%	7	11.48%	11	18.03%	7	11.48%	2	3.28%	3	4.92%	1	1.64%
0905	1170	404	34.53%	337	28.80%	214	18.29%	96	8.21%	51	4.36%	26	2.22%	42	3.59%
0912	27	15	55.56%	8	29.63%	4	14.81%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
0929	26	2	7.69%	7	26.92%	7	26.92%	3	11.54%	3	11.54%	1	3.85%	3	11.54%
0965	1	0	0.00%	1	100.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
09	1285	451	35.10%	360	28.02%	236	18.37%	106	8.25%	56	4.36%	30	2.33%	46	3.58%
1002	9	5	55.56%	4	44.44%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
1013	60	27	45.00%	19	31.67%	10	16.67%	2	3.33%	2	3.33%	0	0.00%	0	0.00%
1038	68	30	44.12%	21	30.88%	5	7.35%	7	10.29%	3	4.41%	0	0.00%	2	2.94%
1050	248	95	38.31%	107	43.15%	25	10.08%	8	3.23%	5	2.02%	6	2.42%	2	0.81%
10	385	157	40.78%	151	39.22%	40	10.39%	17	4.42%	10	2.60%	6	1.56%	4	1.04%
TOTALS	8991	4042	44.96%	2642	29.38%	1124	12.50%	566	6.30%	287	3.19%	159	1.77%	171	1.90%

RADARS (LONG TERM CARE) AS OF 11/07/86; CONTROLS=989829903I (ACTIVE PROVIDERS)

SNF 0 CRITICAL DEF

[SNF certified nursing homes violating none of HCFA's Critical Requirements in most recent inspection -- data as of 11/7/86.]

REG STE	L007> 01	& L007< 05	& L075= 0
0107	327	194	101
0120	184	18	15
0122	569	312	135
0130	87	22	14
0141	204	67	53
0147	57	20	7
01	1428	633	325
0231	283	257	90
0233	1287	564	290
0240	5	5	3
02	1575	826	383
0308	45	28	14
0309	53	6	3
0321	204	116	40
0339	807	577	320
0349	203	86	55
0351	101	40	14
03	1413	853	446
0401	216	190	67
0410	508	434	322
0411	334	284	96
0418	224	93	70
0425	166	135	46
0434	275	180	106
0442	180	104	49
0444	273	93	42
04	2176	1513	798
0514	831	486	257
0515	767	209	69
0523	679	306	239
0524	838	367	278
0536	1164	458	171
0552	468	389	166
05	4747	2219	1180
0604	262	161	61
0619	481	50	25
0632	81	18	8
0637	397	22	10
0645	1208	238	179
06	2429	489	283
0716	474	42	12
0717	410	72	15
0726	397	248	122
0728	226	46	22
07	1507	408	171
0806	202	162	85
0827	101	87	31
0835	125	59	34
0843	132	68	35
0846	93	47	13
0853	29	22	1
08	682	445	204
0903	66	66	38
0905	1398	1161	591
0912	43	27	17
0929	32	26	4
0965	1	1	1
09	1540	1281	651
1002	19	10	9
1013	81	62	42
1038	191	69	38
1050	317	248	138
10	608	389	227
TOTS	18105	9056	4668

TOTAL PROVIDERS SELECTED =

with "0" Critical Deficiencies

TOTAL Numbers of SNF

```
HADARS (LONG TERM CARE)              AS OF 11/07/86: CONTROLS=9898299031 (ACTIVE PROVIDERS)
                              SNF ONE CRIT.
REG    C007> & C007< & C075=
 STE   01        05        1

0107     327      194      35
0120     184       18       3
0122     509      312      92
0130      87       22       1
0141     204       67      14
0147      57       20       7
01      1428      633     152
0231     283      257      84
0233    1287      564     173
0240       5        5       0
02      1575      826     257
0308      45       28       5
0309      53        6       1
0321     204      116      20
0334     807      577     182
0349     203       66      12
0351     101       40      11
03      1413      833     231
0401     216      190      46
0410     508      434      54
0411     334      284      56
0418     224       93      16
0425     168      135      18
0436     275      180      51
0442     180      104      15
0444     273       93      17
04      2178     1513     303
0514     831      488     138
0515     767      209      27
0523     674      308      58
0524     838      367      51
0536    1164      456     107
0552     488      389     157
05      4747     2219     538
0604     262      101      41
0619     451       50      11
0632      81       18       4
0637     347       22       9
0645    1208      238      39
06      2429      489     104
0716     474       92      12
0717     410       72      17
0720     397      248      53
0728     226       66      12
07      1507      408      94
0806     202      162      45
0827     101       87      21
0835     125       59       6
0843     132       60      12
0846      93       47      10
0853      29       22       5
08       682      445      99
0903      66       66       6
0905    1394     1161     297
0912      43       27       6
0929      32       26       3
0965       1        1       0
09      1540     1281     312
1002      19       10       1
1013      81       62      16
1038     191       69      12
1050     317      248      67
10       608      389      96

TOTS   18105     9056    2186
TOTAL PROVIDERS SELECTED =          2186
```

[SNF certified nursing homes violating one or more of HCFA's Critical Requirements in most recent inspection -- as of 11/7/86]

RADAR - (LONG TERM CARE) AS OF 11/07/86; CONTROLS=9698299031 (ACTIVE PROVIDERS)

TWO CRIT

[SNF certified nursing homes violating two or more of HCFA's Critical Requirements in most recent inspection -- as of 11/7/86.]

REG	L0075 &	L0072 &	L075=
STE	01	05	2
0107	327	194	27
0120	154	18	0
0122	589	312	46
0130	97	22	4
0141	204	67	0
0147	57	20	3
01	1428	633	80
0231	283	257	44
0233	1287	564	45
0240	5	5	0
02	1575	826	89
0308	45	28	1
0309	53	6	0
0321	204	116	23
0334	807	577	35
0349	203	86	14
0351	101	40	8
03	1413	853	81
0401	216	190	47
0410	508	434	36
0411	334	284	34
0418	224	93	1
0425	168	135	35
0434	275	180	14
0442	180	104	24
0444	271	93	22
04	2176	1513	213
0514	831	488	52
0515	767	209	40
0523	679	308	6
0524	838	367	22
0536	1164	458	83
0552	468	389	30
05	4747	2219	233
0604	262	161	34
0617	481	50	2
0632	81	18	2
0637	397	22	2
0645	1208	234	15
06	2429	485	55
0716	474	42	11
0717	410	72	19
0726	397	248	37
0728	226	46	5
07	1507	408	72
0806	202	162	20
0827	81	87	17
0835	125	59	10
0843	132	68	10
0849	93	47	8
0853	29	22	3
08	662	445	68
0903	66	66	11
0905	1398	1161	162
0912	43	27	3
0924	32	26	8
0965	1	1	0
09	1540	1281	184
1002	19	10	0
1013	81	62	3
1038	191	69	10
1050	317	248	22
10	608	389	35
TOTS	10105	4056	1110

TOTAL PROVIDERS SELECTED = 1110

RADAR- (LONG TERM CARE) AS OF 11/07/86: CONTROLS=4898299031 (ACTIVE PROVIDERS)

THREE CRIT

[SNF certified nursing homes violating three or more of HCFA's Critical Requirements in most recent inspection -- as of 11/7/86.]

REG STE	L007> 01	& L007< 05	& L075= 3
0107	327	194	19
0120	184	18	0
0122	509	312	16
0130	87	22	2
0141	204	67	0
0147	57	20	2
01	1428	633	39
0231	283	257	20
0233	1287	564	20
0240	5	5	1
02	1575	826	41
0308	45	28	4
0309	33	6	2
0321	204	116	14
0334	807	577	21
0349	203	86	5
0351	101	40	5
03	1413	853	51
0401	216	190	14
0410	508	434	14
0411	334	284	37
0418	224	93	2
0425	166	135	14
0434	275	180	6
0442	180	104	11
0444	273	93	4
04	2176	1513	102
0514	431	488	24
0515	767	209	33
0523	674	308	3
0524	838	367	5
0536	1164	458	46
0552	468	389	31
05	4747	2219	142
0604	262	161	13
0619	481	50	4
0632	81	18	2
0637	397	22	1
0645	1208	238	2
06	2429	489	22
0716	474	42	4
0717	410	72	9
0726	397	248	16
0728	226	46	4
07	1507	408	33
0806	202	162	5
0827	101	87	12
0835	125	54	3
0843	132	68	4
0846	93	47	5
0853	29	22	5
08	682	445	34
0903	66	66	5
0905	1398	1161	65
0912	43	27	1
0929	32	26	4
0985	1	1	0
09	1540	1281	75
1002	19	10	0
1013	81	62	0
1038	191	69	7
1050	317	248	7
10	608	389	14
TOTS	18105	9056	553

TOTAL PROVIDERS SELECTED = 553

```
RADARS (LONG TERM CARE)              AS OF 11/07/86; CONTROLS=989829903I (ACTIVE PROVIDERS)
                              FOUR CRIT

REG    L007> & L007< & L075=
 STE  01        05        4

0107     327     194      6
0120     184      16      0
0122     569     312     13
0130      87      22      0
0141     204      69      0
0147      57      20      1
01      1428     633     20
0231     283     257     11
0233    1287     564     14
0240       5       5      0
02      1575     826     25
0308      45      28      1
0309      53       6      0
0321     204     116      6
0339     807     577     10
0349     203      85      0
0351     101      40      2
03      1413     853     19
0401     216     190     13
0410     508     434      6
0411     334     284     16
0418     224      93      3
0425     166     135      9
0434     275     180      3
0442     180     104      4
0444     273      93      3
04      2176    1513     59
0514     831     488     10
0515     767     209     18
0523     679     306      2
0524     438     367      6
0536    1164     458     19
0552     408     389      3
05      4747    2219     58
0604     262     161      2
0613     481      50      4
0632      81      18      0
0637     397      22      0
0645    1208     238      1
06      2429     489      7
0716     474      42      2
0717     410      72      6
0726     397     248     13
0728     226      46      2
07      1507     408     23
0806     202     162      3
0827     101      87      3
0835     125      59      1
0843     132      68      5
0846      93      47      0
0853      29      22      5
08       682     445     17
0903      68      66      4
0905    1398    1161     23
0912      43      21      0
0929      32      26      6
0965       1       1      0
09      1549    1281     33
1002      19      10      0
1013      81      62      1
1038     191      69      0
1050     317     248      6
10       608     389      7

TOTS   18105    9056    268
TOTAL PROVIDERS SELECTED =         268
```

[SNF certified nursing homes violating four or more of HCFA's Critical Requirements in most recent inspection -- as of 11/7/86.]

RADARS (LONG TERM CARE)　　AS OF 11/07/86: CONTROLS=9898299031 (ACTIVE PROVIDERS)

FIVE CRIT

[SNF certified nursing homes violating five or more of HCFA's Critical Requirements in most recent inspection -- as of 11/7/86.]

REG SIT	L0075 & 01	L0072 & 05	L075= 5
0107	427	194	3
0120	194	18	0
0122	509	312	3
0130	87	22	0
0141	204	67	0
0147	57	20	0
01	1428	633	6
0231	283	257	7
0233	1287	564	10
0240	5	5	0
02	1575	826	17
0308	45	28	1
0309	53	6	0
0321	204	116	5
0339	807	577	7
0349	203	86	0
0351	101	40	0
03	1413	853	13
0401	216	190	2
0410	508	434	2
0411	334	284	5
0418	224	93	0
0425	106	135	7
0434	275	180	0
0442	109	104	0
0444	273	93	3
04	2176	1513	19
0514	831	488	7
0515	767	209	9
0523	679	308	0
0524	838	367	4
0530	1104	458	16
0532	409	389	2
05	4747	2219	38
0604	262	161	5
0619	481	50	2
0632	81	16	1
0637	397	22	0
0645	1208	238	1
06	2429	489	9
0716	474	42	1
0717	410	72	3
0726	397	248	4
0728	225	46	0
07	1507	408	8
0806	202	162	2
0827	101	87	1
0835	125	59	0
0843	132	66	1
0846	93	47	6
0853	29	22	2
08	682	445	12
0903	66	66	1
0905	1398	1161	13
0912	43	27	0
0929	32	26	0
0965	1	1	0
09	1540	1281	14
1002	19	10	0
1013	81	62	0
1036	191	69	1
1050	317	248	5
10	608	389	6
TOTS	18105	9056	142

TOTAL PROVIDERS SELECTED = 142

MADR'S (LONG TERM CARE) AS OF 11/07/86) CONTROLS=[illegible] (ACTIVE PROVIDERS)

OVER FIVE

[SNF certified nursing homes violating more than five of HCFA's Critical Requirements in most recent inspection -- as of 11/7/86.]

REG STE	COUNT> 01	COUNT> 05	CO/5> 5
0107	327	194	3
0120	154	18	0
0122	584	312	7
0130	87	22	1
0141	219	67	0
0147	57	20	0
01	1428	633	11
0231	281	257	1
0233	1287	564	12
0240	5	5	1
02	1573	826	14
0308	45	28	2
0309	51	5	0
0321	204	116	8
0339	807	578	2
0349	203	86	0
0351	101	40	0
03	1411	853	12
0401	215	190	1
0410	508	434	0
0411	334	284	8
0418	224	93	1
0425	188	135	6
0434	275	180	0
0442	180	104	1
0444	273	93	2
04	2176	1513	19
0514	831	488	0
0515	767	209	13
0523	679	308	0
0524	838	367	1
0536	1164	458	16
0552	406	389	0
05	4787	2219	30
0604	262	161	5
0619	481	50	2
0632	81	18	1
0637	397	22	0
0645	1208	238	1
06	2429	489	9
0716	474	42	0
0717	410	72	3
0726	397	248	3
0728	226	46	1
07	1507	408	7
0806	202	162	2
0827	101	87	2
0835	125	59	0
0843	132	66	1
0846	43	47	5
0853	29	24	1
08	632	445	11
0903	66	66	1
0905	1498	1161	10
0912	43	27	0
0924	32	26	1
0965	1	1	0
09	1640	1281	12
1002	14	10	0
1013	91	62	0
1038	141	69	1
1050	317	248	3
10	508	389	4
TOTS	18105	9056	129

TOTAL PROVIDERS SELECTED = 129

[**COMMITTEE STAFF NOTE:** The following print out displays aggregate data on federally certified nursing homes' violations of the Committee staff list of selected regulatory requirements. The data are arranged to display for each State, federal region, and the Nation, the number of times a specific regulatory requirement on the Committee staff list was violated. Data for Skilled Nursing requirements, as well as for selected Intermediate Care requirements are included, but violations of Intermediate Care standards were not analyzed by Committee staff.

To read the print out: The total number of certified SNFs and ICFs appears in the column labeled "FACIL". Under the column heading "CODE" are listed each of the regulatory requirements selected, after study, by Committee staff as being most closely related to patient health and safety. Please note that SNF requirements are preceded by the prefix "F", and ICF requirements are preceded by the prefix "T". On the page displaying national data, therefore, 8,852 SNFs' inspection report findings are summarized for each of the 25 key SNF regulatory standards identified by Committee staff. Similarly, 7,242 ICFs' inspection report findings are detailed for the 17 key ICF standards. Under the column headings "NONE" and "%" appear the number and percentage of SNFs or ICFs that were not cited for violation of the regulatory standard at any time during the previous four inspections. Data presented under the heading "ONE" and "%" reveal the number and percentage of facilities cited for at least one violation of the regulatory requirement during the four most recent inspections. The number of facilities found in violation of a requirement twice, three or four times during the previous four inspections is listed under the columns headed "TWO", "THREE", or "FOUR", adjacent to respective percentages.

The next set of columns depict the number of violations of each regulatory requirement identified during inspections in each year since 1982. **1985 inspection data are very incomplete and cannot be relied upon,** due to slow processing of inspection findings by States and HCFA. (For data based upon a similar analysis of 1985 and 1986 inspection findings, please see the print outs of violations of HCFA's set of "Critical Requirements", also in this appendix.)]

	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NATIONAL	8852	F015	8388	95	408	5	50	1	6	0	0	0	109	1	154	2	125	1	91	1
		F062	8552	97	256	3	34	0	10	0	0	0	63	1	98	1	109	1	59	1
		F070	8556	97	275	3	20	0	1	0	0	0	70	1	98	1	70	1	49	1
		F071	8650	98	190	2	11	0	1	0	0	0	44	0	60	1	50	1	36	0
		F073	7075	80	1355	15	317	4	92	1	13	0	585	7	656	7	450	5	375	4
		F101	8757	99	92	1	3	0	0	0	0	0	24	0	23	0	24	0	20	0
		F105	8462	96	353	4	33	0	3	0	1	0	74	1	128	1	111	1	73	1
		F111	6982	79	1459	16	331	4	71	1	9	0	443	5	603	7	539	6	404	5
		F112	6618	75	1666	19	450	5	99	1	19	0	559	6	767	9	652	7	543	6
		F123	8017	91	735	8	92	1	8	0	0	0	153	2	292	3	207	2	181	2
		F134	7359	83	1178	13	257	3	50	1	8	0	325	4	489	6	444	5	386	4
		F135	6569	74	1660	19	497	6	107	1	19	0	694	8	820	9	642	7	526	6
		F136	4405	50	1929	22	1200	14	842	10	476	5	1844	21	2311	26	1952	22	1596	18
		F173	7505	85	1096	12	219	2	27	0	5	0	307	3	386	4	382	4	373	4
		F175	6269	71	1813	20	583	7	160	2	27	0	821	9	954	11	794	9	625	7
		F176	5460	62	2197	25	862	10	272	3	61	1	979	11	1180	13	1101	12	1006	11
		F177	7890	89	813	9	128	1	20	0	1	0	266	3	338	4	261	3	176	2
		F178	6412	72	1757	20	530	6	134	2	19	0	809	9	925	10	695	8	528	6
		F180	6320	71	1731	20	601	7	173	2	27	0	783	9	986	11	811	9	582	7
		F181	8385	95	425	5	41	0	0	0	1	0	112	1	145	2	111	1	100	1
		F182	8324	94	482	5	45	1	1	0	0	0	107	1	153	2	112	1	115	1
		F186	5665	64	2164	24	736	8	236	3	51	1	839	9	1206	14	1007	11	838	9
		F189	7937	90	761	9	130	1	21	0	3	0	215	2	301	3	258	3	213	2
		F190	4841	55	2466	28	1053	12	389	4	103	1	1325	15	1538	17	1332	15	1147	13
		F191	7585	86	1085	12	167	2	15	0	0	0	248	3	406	5	328	4	287	3
		F609			57		0		0		0		45		9		1		0	
		F636			248		10		0		0		188		57		15		2	
		F640			331		15		0		0		265		67		18		5	
		F648			216		8		0		0		155		49		17		6	
		F650			380		15		0		0		291		87		24		2	
	7242	T094	5679	78	1187	16	276	4	86	1	14	0	275	4	474	7	499	7	452	6
		T095	4655	64	1596	22	628	9	281	4	82	1	710	10	1046	14	937	13	764	11
		T103	5513	76	1328	18	308	4	83	1	10	0	365	5	539	7	547	8	478	7
		T105	4874	67	1431	20	592	8	253	3	92	1	802	11	974	13	864	12	710	10
		T117	2880	40	1820	25	1236	17	880	12	426	6	1585	22	2155	30	1903	26	1739	24
		T118	6836	94	371	5	35	0	0	0	0	0	80	1	105	1	97	1	80	1
		T127	6151	85	929	13	141	2	20	0	1	0	162	2	307	4	323	4	269	4
		T129	5395	74	1404	19	354	5	83	1	6	0	357	5	596	8	618	9	444	6
		T135	6731	93	409	6	86	1	14	0	2	0	94	1	133	2	179	2	137	2
		T139	4783	66	1607	22	633	9	177	2	42	1	593	8	846	12	796	11	783	11
		T143	4716	65	1629	22	638	9	209	3	50	1	585	8	955	13	886	12	716	10
		T144	5093	70	1495	21	494	7	138	2	22	0	432	6	742	10	721	10	577	8
		T152	6123	85	728	10	247	3	97	1	47	1	326	5	446	6	447	6	341	5
		T163	5125	71	1520	21	473	7	110	2	14	0	463	6	688	10	721	10	524	7
		T164	6573	91	566	8	82	1	19	0	2	0	185	3	195	3	143	2	136	2
		T165	6719	93	466	6	49	1	8	0	0	0	114	2	127	2	121	2	123	2
		T169	7095	98	120	2	20	0	5	0	2	0	23	0	22	0	32	0	31	0
		T309			12		1		1		0		0		3		3		1	
		T336			55		14		1		0		1		8		29		21	
		T340			87		29		7		0		0		20		52		35	
		T348			82		13		2		0		0		9		13		12	
		T350			76		13		3		0		0		5		30		12	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 01	673	F015	663	99	7	1	1	0	1	0	1	0	1	0	1	0	1	0	1	0
		F062	656	97	17	3	0	0	0	0	0	0	1	0	4	1	4	1	7	1
		F070	668	99	5	1	0	0	0	0	0	0	0	0	2	0	1	0	0	0
		F071	650	97	21	3	1	0	1	0	0	0	4	1	5	1	6	1	5	1
		F073	521	77	129	19	20	3	3	0	0	0	24	4	59	9	33	5	17	3
		F101	671	100	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
		F105	632	94	36	5	3	0	1	0	1	0	4	1	15	2	13	2	10	1
		F111	438	65	178	26	46	7	9	1	2	0	38	6	90	13	76	11	34	5
		F112	475	71	145	22	46	7	6	1	1	0	40	6	72	11	62	9	39	6
		F123	646	96	25	4	2	0	0	0	0	0	7	1	5	1	3	0	9	1
		F134	552	82	95	14	21	3	5	1	0	0	20	3	37	5	30	4	43	6
		F135	384	57	204	30	64	10	20	3	1	0	129	19	126	19	70	10	43	6
		F136	317	47	132	20	95	14	105	16	24	4	43	6	163	24	180	27	195	29
		F173	592	88	70	10	11	2	0	0	0	0	20	3	18	3	20	3	26	4
		F175	475	71	132	20	46	7	16	2	4	1	65	10	94	14	51	8	46	7
		F176	462	69	138	21	61	9	10	1	2	0	37	5	56	8	38	6	93	14
		F177	651	97	19	3	3	0	0	0	0	0	2	0	7	1	5	1	6	1
		F178	539	80	104	15	26	4	4	1	0	0	17	3	36	5	42	6	37	5
		F180	529	79	88	13	46	7	8	1	2	0	25	4	43	6	36	5	54	8
		F181	665	99	7	1	1	0	0	0	0	0	4	1	1	0	2	0	1	0
		F182	641	95	28	4	4	1	0	0	0	0	5	1	12	2	2	0	10	1
		F186	482	72	152	23	31	5	7	1	1	0	23	3	46	7	39	6	55	8
		F189	645	96	27	4	1	0	0	0	0	0	5	1	5	1	6	1	5	1
		F190	489	73	138	21	39	6	7	1	0	0	24	4	52	8	58	9	38	6
		F191	529	79	121	18	23	3	0	0	0	0	17	3	43	6	36	5	35	5
		F636			19		4		0		0		10		8		6		2	
		F640			46		1		0		0		31		12		3		2	
		F648			9		1		0		0		5		4		2		0	
		F650			40		1		0		0		28		11		2		1	
	724	T094	551	76	124	17	29	4	18	2	2	0	37	5	66	9	59	8	37	5
		T095	537	74	140	19	34	5	10	1	3	0	38	5	82	11	87	12	26	4
		T103	581	80	108	15	24	3	9	1	2	0	16	2	45	6	69	10	39	5
		T105	526	73	84	12	52	7	36	5	26	4	86	12	105	15	113	16	62	9
		T117	378	52	179	25	97	13	52	7	18	2	103	14	149	21	148	20	122	17
		T118	693	96	28	4	3	0	0	0	0	0	1	0	10	1	8	1	8	1
		T127	585	81	116	16	22	3	1	0	0	0	27	4	50	7	32	4	15	2
		T129	509	70	161	22	40	6	13	2	1	0	54	7	83	11	78	11	34	5
		T135	643	89	65	9	15	2	1	0	0	0	2	0	18	2	47	6	31	4
		T139	574	79	102	14	36	5	11	2	1	0	48	7	56	8	38	5	28	4
		T143	542	75	142	20	31	4	9	1	0	0	24	3	50	7	62	9	35	5
		T144	564	78	127	18	29	4	4	1	0	0	24	3	50	7	50	7	24	3
		T152	613	85	71	10	37	5	3	0	0	0	3	0	16	2	77	11	55	8
		T163	524	72	164	23	31	4	5	1	0	0	48	7	70	10	66	9	24	3
		T164	656	91	48	7	12	2	6	1	2	0	18	2	14	2	20	3	35	5
		T165	678	94	42	6	4	1	0	0	0	0	4	1	11	2	14	2	13	2
		T169	670	93	36	5	13	2	4	1	1	0	4	1	5	1	19	3	14	2
		T336			15		9		0		0		0		3		9		9	
		T340			15		15		3		0		0		5		15		13	
		T348			12		2		0		0		0		1		1		4	
		T350			10		1		0		0		0		0		6		4	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
CONNECTICUT	209	F015	208	100	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
		F070	207	99	2	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0
		F071	190	91	17	8	1	0	1	0	0	0	3	1	5	2	6	3	4	2
		F073	153	73	49	23	6	3	1	0	0	0	5	2	10	5	1	0	15	7
		F105	202	97	7	3	0	0	0	0	0	0	0	0	1	0	5	2	0	0
		F111	113	54	72	34	20	10	3	1	1	0	11	5	29	14	36	17	16	8
		F112	111	53	63	30	32	15	3	1	0	0	20	10	33	16	39	19	23	11
		F123	204	98	5	2	0	0	0	0	0	0	1	0	0	0	1	0	3	1
		F134	174	83	25	12	9	4	1	0	0	0	1	0	16	8	10	5	12	6
		F135	56	27	104	50	37	18	11	5	1	0	84	40	69	33	23	11	28	13
		F136	8	4	20	10	59	28	99	47	23	11	4	2	109	52	138	66	167	80
		F173	170	81	34	16	5	2	0	0	0	0	10	5	8	4	5	2	17	8
		F175	107	51	56	27	29	14	13	6	4	2	40	19	47	22	23	11	38	18
		F176	59	28	85	41	53	25	10	5	2	1	22	11	43	21	27	13	83	40
		F177	195	93	11	5	3	1	0	0	0	0	1	0	6	3	2	1	6	3
		F178	117	56	69	33	20	10	3	1	0	0	9	4	26	12	27	13	31	15
		F180	92	44	64	31	44	21	7	3	2	1	21	10	32	15	28	13	51	24
		F181	208	100	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		F182	195	93	11	5	3	1	0	0	0	0	1	0	4	2	1	0	8	4
		F186	91	44	85	41	25	12	7	3	1	0	15	7	20	10	22	11	50	24
		F189	207	99	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F190	109	52	73	35	21	10	6	3	0	0	10	5	37	18	25	12	25	12
		F191	144	69	52	25	13	6	0	0	0	0	3	1	16	8	18	9	21	10
		F636	201		8		0		0		0		5		3		0		0	
		F640	167		42		0		0		0		30		12		0		0	
		F648	206		3		0		0		0		2		1		0		0	
		F650	172		37		0		0		0		27		10		0		0	
	87	T094	64	74	15	17	4	5	4	5	0	0	1	1	10	11	8	9	6	7
		T095	57	66	17	20	6	7	5	6	2	2	9	10	10	11	16	18	7	8
		T103	74	85	9	10	3	3	0	0	1	1	3	3	3	3	3	3	5	6
		T105	72	83	12	14	1	1	2	2	0	0	3	3	5	6	8	9	1	1
		T117	54	62	14	16	12	14	3	3	4	5	9	10	14	16	15	17	14	16
		T118	82	94	4	5	1	1	0	0	0	0	1	1	1	1	1	1	0	0
		T127	78	90	8	9	1	1	0	0	0	0	0	0	3	3	4	5	1	1
		T129	79	91	7	8	1	1	0	0	0	0	2	2	2	2	4	5	0	0
		T139	63	72	12	14	7	8	5	6	0	0	5	6	11	13	6	7	9	10
		T143	71	82	15	17	1	1	0	0	0	0	5	6	3	3	2	2	0	0
		T144	76	87	6	7	4	5	1	1	0	0	1	1	3	3	2	2	4	5
		T152	86	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		T163	73	84	11	13	2	2	1	1	0	0	2	2	2	2	7	8	2	2
		T164	78	90	6	7	2	2	1	1	0	0	3	3	2	2	3	3	4	5
		T165	77	89	9	10	1	1	0	0	0	0	2	2	2	2	2	2	3	3
		T169	85	98	2	2	0	0	0	0	0	0	0	0	0	0	1	1	1	1
		T336			14		7		0		0		0		2		9		7	
		T340			12		15		3		0		0		5		14		12	
		T348			8		1		0		0		0		0		0		3	
		T350			7		1		0		0		0		0		6		3	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MAINE	19	P015	17	89	2	11	0	0	0	0	0	0	0	0	0	0	0	0	1	5
		P062	15	79	4	21	0	0	0	0	0	0	0	0	0	0	1	5	3	16
		P070	18	95	1	5	0	0	0	0	0	0	0	0	1	5	0	0	0	0
		P073	16	84	3	16	0	0	0	0	0	0	0	0	0	0	1	5	0	0
		P105	13	68	6	32	0	0	0	0	0	0	0	0	0	0	2	11	4	21
		P111	13	68	4	21	1	5	1	5	0	0	1	5	2	11	2	11	0	0
		P112	12	63	6	32	1	5	0	0	0	0	3	16	0	0	0	0	1	5
		P123	16	84	3	16	0	0	0	0	0	0	0	0	0	0	0	0	2	11
		P134	8	42	7	37	4	21	0	0	0	0	0	0	0	0	6	32	9	47
		P135	6	32	12	63	1	5	0	0	0	0	1	5	2	11	5	26	4	21
		P136	13	68	5	26	1	5	0	0	0	0	3	16	2	11	1	5	0	0
		P173	17	89	2	11	0	0	0	0	0	0	0	0	0	0	1	5	0	0
		P175	18	95	1	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		P176	14	74	4	21	1	5	0	0	0	0	3	16	1	5	1	5	0	0
		P178	16	84	3	16	0	0	0	0	0	0	0	0	1	5	2	11	0	0
		P180	16	84	3	16	0	0	0	0	0	0	0	0	3	16	0	0	0	0
		P186	18	95	0	0	1	5	0	0	0	0	1	5	1	5	0	0	0	0
		P189	15	79	4	21	0	0	0	0	0	0	0	0	0	0	3	16	1	5
		P190	11	58	5	26	3	16	0	0	0	0	4	21	1	5	4	21	0	0
		P191	17	89	2	11	0	0	0	0	0	0	1	5	0	0	0	0	0	0
		P636			7		2		0		0		3		3		4		1	
		P640			2		0		0		0		0		0		1		1	
		P648			2		0		0		0		0		2		0		0	
		P650			2		1		0		0		1		1		1		1	
	136	T094	80	59	29	21	16	12	9	7	2	1	14	10	24	18	32	24	22	16
		T095	104	76	25	18	7	5	0	0	0	0	8	6	6	4	16	12	8	6
		T103	85	63	43	32	7	5	1	1	0	0	4	3	8	6	29	21	15	11
		T105	16	12	22	16	38	28	34	25	26	19	76	56	81	60	78	57	47	35
		T117	19	14	35	26	38	28	32	24	12	9	59	43	57	42	60	44	57	42
		T118	132	97	4	3	0	0	0	0	0	0	0	0	1	1	2	1	0	0
		T127	87	64	34	25	14	10	1	1	0	0	20	15	22	16	11	8	3	2
		T129	47	35	53	39	24	18	11	8	1	1	35	26	36	26	47	35	17	13
		T135	73	54	47	35	15	11	1	1	0	0	1	1	9	7	42	31	28	21
		T139	72	53	39	29	20	15	4	3	1	1	35	26	33	24	10	7	7	5
		T143	114	84	21	15	1	1	0	0	0	0	4	3	8	6	7	5	1	1
		T144	118	87	18	13	0	0	0	0	0	0	7	5	4	3	6	4	0	0
		T152	36	26	63	46	34	25	3	2	0	0	0	0	12	9	73	54	52	38
		T163	86	63	39	29	10	7	1	1	0	0	18	13	13	10	8	6	10	7
		T164	127	93	9	7	0	0	0	0	0	0	4	3	3	2	0	0	2	1
		T165	125	92	9	7	2	1	0	0	0	0	2	1	1	1	8	6	2	1
		T169	112	82	19	14	5	4	0	0	0	0	0	0	3	2	13	10	9	7
		T336			1		2		0		0		0		1		0		2	
		T348			1		0		0		0		0		1		0		0	
		T350			1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MASSACHUSETTS	337	F015	335	99	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1
		F062	325	96	12	4	0	0	0	0	0	0	1	0	4	1	3	1	4	1
		F070	335	99	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F071	334	99	3	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0
		F073	255	76	66	20	14	4	2	1	0	0	19	6	48	14	29	9	0	0
		F101	335	99	2	1	0	0	0	0	0	0	2	1	0	0	0	0	0	0
		F105	310	92	22	7	3	1	1	0	1	0	4	1	14	4	6	2	5	1
		F111	222	66	86	26	23	7	5	1	1	0	23	7	54	16	35	10	15	4
		F112	259	77	62	18	12	4	3	1	1	0	15	4	35	10	18	5	11	3
		F123	321	95	14	4	2	1	0	0	0	0	4	1	5	1	2	1	4	1
		F134	294	87	35	10	5	1	3	1	0	0	12	4	13	4	9	3	11	3
		F135	234	69	73	22	23	7	7	2	0	0	39	12	49	15	35	10	5	1
		F136	227	67	80	24	25	7	5	1	0	0	23	7	38	11	30	9	21	6
		F173	303	90	28	8	6	2	0	0	0	0	8	2	9	3	12	4	8	2
		F175	258	77	59	18	17	5	3	1	0	0	23	7	40	12	26	8	6	2
		F176	298	88	33	10	6	2	0	0	0	0	11	3	10	3	5	1	6	2
		F177	331	98	6	2	0	0	0	0	0	0	1	0	1	0	1	0	0	0
		F178	320	95	14	4	3	1	0	0	0	0	3	1	4	1	5	1	2	1
		F180	329	98	7	2	1	0	0	0	0	0	0	0	3	1	2	1	0	0
		F181	335	99	1	0	1	0	0	0	0	0	2	1	0	0	1	0	0	0
		F182	327	97	10	3	0	0	0	0	0	0	2	1	7	2	0	0	0	0
		F186	287	85	49	15	1	0	0	0	0	0	5	1	19	6	8	2	4	1
		F189	319	95	17	5	1	0	0	0	0	0	3	1	5	1	3	1	4	1
		F190	297	88	33	10	7	2	0	0	0	0	5	1	10	3	12	4	10	3
		F191	269	80	59	18	9	3	0	0	0	0	12	4	24	7	16	5	13	4
	384	T094	325	85	57	15	1	0	1	0	0	0	8	2	13	3	10	3	7	2
		T095	279	73	86	22	16	4	2	1	1	0	17	4	61	16	38	10	7	2
		T103	332	86	44	11	6	2	2	1	0	0	6	2	16	4	17	4	12	3
		T105	345	90	37	10	2	1	0	0	0	0	1	0	12	3	13	3	8	2
		T117	249	65	99	26	27	7	8	2	1	0	15	4	50	13	55	14	38	10
		T118	362	94	20	5	2	1	0	0	0	0	0	0	8	2	5	1	8	2
		T127	323	84	57	15	4	1	0	0	0	0	2	1	18	5	10	3	9	2
		T129	299	78	78	20	7	2	0	0	0	0	9	2	29	8	17	4	11	3
		T135	369	96	15	4	0	0	0	0	0	0	1	0	9	2	4	1	1	0
		T139	352	92	31	8	1	0	0	0	0	0	3	1	5	1	13	3	4	1
		T143	267	70	85	22	25	7	7	2	0	0	13	3	34	9	39	10	26	7
		T144	269	70	89	23	23	6	3	1	0	0	16	4	42	11	33	9	18	5
		T152	382	99	2	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0
		T163	281	73	86	22	14	4	3	1	0	0	22	6	49	13	44	11	2	1
		T164	337	88	30	8	10	3	5	1	2	1	11	3	9	2	16	4	28	7
		T165	363	95	20	5	1	0	0	0	0	0	0	0	6	2	3	1	8	2
		T169	369	96	8	2	3	1	4	1	0	0	2	1	2	1	4	1	3	1
		T348			1		0		0		0		0		0		0		0	
		T350			1		0		0		0		0		0		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NEW HAMPSHIRE	22	F015	21	95	1	5	0	0	0	0	0	0	0	0	1	5	0	0	0	0
		F073	16	73	6	27	0	0	0	0	0	0	0	0	0	0	2	9	0	0
		F111	18	82	4	18	0	0	0	0	0	0	1	5	1	5	0	0	0	0
		F112	20	91	2	9	0	0	0	0	0	0	0	0	2	9	0	0	0	0
		F123	20	91	2	9	0	0	0	0	0	0	2	9	0	0	0	0	0	0
		F134	21	95	0	0	1	5	0	0	0	0	0	0	1	5	1	5	0	0
		F135	20	91	1	5	1	5	0	0	0	0	0	0	1	5	1	5	1	5
		F136	19	86	3	14	0	0	0	0	0	0	2	9	0	0	0	0	0	0
		F173	20	91	2	9	0	0	0	0	0	0	0	0	1	5	1	5	0	0
		F175	20	91	2	9	0	0	0	0	0	0	0	0	1	5	1	5	0	0
		F176	20	91	2	9	0	0	0	0	0	0	0	0	1	5	1	5	0	0
		F177	20	91	2	9	0	0	0	0	0	0	0	0	0	0	2	9	0	0
		F178	20	91	2	9	0	0	0	0	0	0	0	0	0	0	2	9	0	0
		F180	20	91	2	9	0	0	0	0	0	0	0	0	1	5	1	5	0	0
		F181	20	91	2	9	0	0	0	0	0	0	1	5	0	0	0	0	0	0
		F182	19	86	2	9	1	5	0	0	0	0	2	9	0	0	0	0	0	0
		F186	18	82	4	18	0	0	0	0	0	0	1	5	1	5	0	0	0	0
		F189	20	91	2	9	0	0	0	0	0	0	1	5	0	0	0	0	0	0
		F190	15	68	7	32	0	0	0	0	0	0	1	5	2	9	1	5	0	0
		F191	19	86	3	14	0	0	0	0	0	0	1	5	0	0	1	5	0	0
	49	T094	25	51	15	31	6	12	3	6	0	0	13	27	15	31	3	6	1	2
		T095	45	92	4	8	0	0	0	0	0	0	2	4	0	0	1	2	1	2
		T103	47	96	2	4	0	0	0	0	0	0	1	2	1	2	0	0	0	0
		T105	42	86	7	14	0	0	0	0	0	0	4	8	0	0	1	2	1	2
		T117	6	12	17	35	16	33	9	18	1	2	15	31	27	55	13	27	7	14
		T127	41	84	8	16	0	0	0	0	0	0	3	6	4	8	0	0	1	2
		T129	26	53	15	31	6	12	2	4	0	0	8	16	15	31	2	4	3	6
		T135	48	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		T139	34	69	9	18	5	10	1	2	0	0	2	4	3	6	6	12	3	6
		T143	41	84	7	14	1	2	0	0	0	0	0	0	3	6	4	8	0	0
		T144	48	98	1	2	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		T152	46	94	2	4	1	2	0	0	0	0	1	2	2	4	1	2	0	0
		T163	33	67	12	24	4	8	0	0	0	0	6	12	5	10	2	4	3	6
		T164	48	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T165	48	98	1	2	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		T169	48	98	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
RHODE ISLAND	65	F015	64	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		F062	64	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F071	64	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F073	62	95	3	5	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		F111	55	85	9	14	1	2	0	0	0	0	2	3	3	5	2	3	0	0
		F112	55	85	9	14	1	2	0	0	0	0	2	3	1	2	5	8	2	3
		F123	64	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F134	64	98	1	2	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		F135	58	89	7	11	0	0	0	0	0	0	4	6	1	2	1	2	0	0
		F136	38	58	18	28	7	11	1	2	1	2	9	14	9	14	10	15	4	6
		F173	63	97	2	3	0	0	0	0	0	0	2	3	0	0	0	0	0	0
		F175	54	83	11	17	0	0	0	0	0	0	2	3	6	9	0	0	0	0
		F176	54	83	10	15	1	2	0	0	0	0	1	2	1	2	3	5	1	2
		F178	45	69	16	25	3	5	1	2	0	0	5	8	5	8	6	9	4	6
		F180	51	78	12	18	1	2	1	2	0	0	4	6	4	6	5	8	3	5
		F181	63	97	2	3	0	0	0	0	0	0	1	2	0	0	1	2	0	0
		F182	60	92	5	8	0	0	0	0	0	0	0	0	1	2	1	2	2	3
		F186	48	74	13	20	4	6	0	0	0	0	1	2	5	8	9	14	1	2
		F189	63	97	2	3	0	0	0	0	0	0	1	2	0	0	0	0	0	0
		F190	40	62	16	25	8	12	1	2	0	0	3	5	2	3	13	20	3	5
		F191	62	95	2	3	1	2	0	0	0	0	0	0	1	2	1	2	0	0
		F636			4		1		0		0		1		1		2		1	
		F640			1		1		0		0		0		0		2		1	
		F648			4		1		0		0		3		1		2		0	
		F650			1		0		0		0		0		0		1		0	
	45	T094	42	93	3	7	0	0	0	0	0	0	1	2	1	2	0	0	0	0
		T095	44	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		T103	41	91	3	7	1	2	0	0	0	0	1	2	1	2	2	4	0	0
		T105	44	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T117	36	80	7	16	2	4	0	0	0	0	1	2	0	0	2	4	4	9
		T127	43	96	2	4	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		T129	39	87	6	13	0	0	0	0	0	0	0	0	0	0	3	7	3	7
		T139	39	87	4	9	2	4	0	0	0	0	1	2	1	2	1	2	2	4
		T143	38	84	7	16	0	0	0	0	0	0	0	0	0	0	2	4	2	4
		T144	38	84	6	13	1	2	0	0	0	0	0	0	0	0	2	4	1	2
		T152	44	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		T163	30	67	14	31	1	2	0	0	0	0	0	0	1	2	4	9	7	16
		T164	44	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
VERMONT	21	F073	19	90	2	10	0	0	0	0	0	0	0	0	0	0	0	0	2	10
		F105	20	95	1	5	0	0	0	0	0	0	0	0	0	0	0	0	1	5
		F111	17	81	3	14	1	5	0	0	0	0	0	0	1	5	1	5	3	14
		F112	18	86	3	14	0	0	0	0	0	0	0	0	1	5	0	0	2	10
		F134	18	86	2	10	0	0	1	5	0	0	0	0	1	5	1	5	2	10
		F135	10	48	7	33	2	10	2	10	0	0	1	5	4	19	5	24	5	24
		F136	12	57	6	29	3	14	0	0	0	0	2	10	5	24	1	5	3	14
		F173	19	90	2	10	0	0	0	0	0	0	0	0	0	0	1	5	1	5
		F175	18	86	3	14	0	0	0	0	0	0	0	0	0	0	1	5	2	10
		F176	17	81	4	19	0	0	0	0	0	0	0	0	0	0	1	5	3	14
		F181	20	95	1	5	0	0	0	0	0	0	0	0	0	0	0	0	1	5
		F186	20	95	1	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F190	17	81	4	19	0	0	0	0	0	0	1	5	0	0	3	14	0	0
		F191	18	86	3	14	0	0	0	0	0	0	0	0	2	10	0	0	1	5
		F636			0		1		0		0		1		1		0		0	
		F640			1		0		0		0		1		0		0		0	
	23	T094	15	65	5	22	2	9	1	4	0	0	0	0	3	13	6	26	1	4
		T095	8	35	7	30	5	22	3	13	0	0	2	9	5	22	15	65	3	13
		T103	2	9	7	30	7	30	6	26	1	4	1	4	16	70	18	78	7	30
		T105	7	30	5	22	11	48	0	0	0	0	2	9	7	30	13	57	5	22
		T117	14	61	7	30	2	9	0	0	0	0	4	17	1	4	3	13	2	9
		T127	13	57	7	30	3	13	0	0	0	0	2	9	3	13	6	26	1	4
		T129	19	83	2	9	2	9	0	0	0	0	0	0	1	4	5	22	0	0
		T135	21	91	2	9	0	0	0	0	0	0	0	0	0	0	0	0	2	9
		T139	14	61	7	30	1	4	1	4	0	0	2	9	3	13	2	9	3	13
		T143	11	48	7	30	3	13	2	9	0	0	2	9	2	9	8	35	6	26
		T144	15	65	7	30	1	4	0	0	0	0	0	0	0	0	7	30	1	4
		T152	19	83	2	9	2	9	0	0	0	0	1	4	2	9	2	9	1	4
		T163	21	91	2	9	0	0	0	0	0	0	0	0	0	0	1	4	0	0
		T164	22	96	1	4	0	0	0	0	0	0	0	0	0	0	0	0	1	4
		T165	20	87	3	13	0	0	0	0	0	0	0	0	1	4	1	4	0	0
		T169	11	48	7	30	5	22	0	0	0	0	2	9	0	0	1	4	1	4
		T340			3		0		0		0		0		0		1		1	
		T348			2		1		0		0		0		0		1		1	
		T350			1		0		0		0		0		0		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 02	807	F015	721	89	74	9	9	1	3	0	0	0	10	1	30	4	29	4	21	3
		F062	673	83	99	12	25	3	10	1	0	0	32	4	51	6	62	8	25	3
		F070	745	92	59	7	3	0	0	0	0	0	3	0	12	1	17	2	22	3
		F071	767	95	36	4	4	0	0	0	0	0	11	1	13	2	11	1	5	1
		F073	755	94	49	6	2	0	1	0	0	0	7	1	13	2	18	2	10	1
		F101	782	97	23	3	2	0	0	0	0	0	5	1	11	1	5	1	5	1
		F105	680	84	111	14	14	2	2	0	0	0	29	4	52	6	36	4	21	3
		F111	631	78	147	18	25	3	4	0	0	0	34	4	67	8	44	5	33	4
		F112	588	73	152	19	41	5	20	2	6	1	43	5	94	12	64	8	63	8
		F123	698	86	91	11	16	2	2	0	0	0	12	1	31	4	38	5	36	4
		F134	711	88	83	10	12	1	1	0	0	0	7	1	22	3	34	4	33	4
		F135	722	89	70	9	15	2	0	0	0	0	10	1	22	3	23	3	27	3
		F136	500	62	141	17	72	9	54	7	40	5	95	12	147	18	118	15	143	18
		F173	596	74	157	19	49	6	3	0	2	0	35	4	64	8	67	8	80	10
		F175	558	69	183	23	53	7	11	1	2	0	53	7	72	9	75	9	91	11
		F176	465	58	214	27	94	12	26	3	8	1	74	9	122	15	103	13	142	18
		F177	627	78	151	19	27	3	2	0	0	0	43	5	62	8	59	7	37	5
		F178	549	68	196	24	56	7	6	1	0	0	61	8	90	11	71	9	64	8
		F180	623	77	144	18	34	4	6	1	0	0	42	5	55	7	69	9	39	5
		F181	676	84	111	14	19	2	0	0	1	0	24	3	45	6	38	5	34	4
		F182	761	94	38	5	7	1	1	0	0	0	9	1	17	2	16	2	7	1
		F186	517	64	184	23	75	9	26	3	5	1	59	7	111	14	88	11	110	14
		F189	539	67	207	26	46	6	14	2	1	0	52	6	110	14	91	11	68	8
		F190	393	49	222	28	110	14	56	7	26	3	127	16	196	24	152	19	153	19
		F191	653	81	133	16	20	2	1	0	0	0	22	3	55	7	40	5	34	4
		F609	802		5		0		0		0		4		1		0		0	
		F636	798		9		0		0		0		6		1		0		0	
		F640	805		2		0		0		0		1		1		0		0	
		F648	795		12		0		0		0		7		4		0		0	
		F650	773		33		1		0		0		26		6		0		0	
	407	T094	379	93	22	5	6	1	0	0	0	0	6	1	7	2	5	1	7	2
		T095	365	90	35	9	4	1	3	1	0	0	1	0	13	3	10	2	13	3
		T103	329	81	52	13	20	5	6	1	0	0	9	2	31	8	31	8	33	8
		T105	365	90	34	8	8	2	0	0	0	0	4	1	13	3	11	3	17	4
		T117	285	70	74	18	31	8	10	2	7	2	15	4	47	12	40	10	33	8
		T118	397	98	8	2	2	0	0	0	0	0	0	0	0	0	7	2	2	0
		T127	372	91	31	8	2	0	2	0	0	0	1	0	13	3	9	2	9	2
		T129	349	86	48	12	6	1	4	1	0	0	7	2	19	5	20	5	14	3
		T135	382	94	24	6	1	0	0	0	0	0	0	0	8	2	8	2	6	1
		T139	382	94	22	5	3	1	0	0	0	0	3	1	2	0	4	1	7	2
		T143	389	96	17	4	1	0	0	0	0	0	0	0	5	1	4	1	3	1
		T144	389	96	18	4	0	0	0	0	0	0	0	0	3	1	3	1	3	1
		T152	383	94	19	5	5	1	0	0	0	0	1	0	8	2	8	2	9	2
		T163	384	94	20	5	3	1	0	0	0	0	1	0	7	2	7	2	0	0
		T164	404	99	—3	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
		T165	380	93	23	6	4	1	0	0	0	0	4	1	10	2	8	2	4	1
		T169	402	99	4	1	1	0	0	0	0	0	0	0	1	0	1	0	1	0
		T309	406		1		0		0		0		0		0		0		0	
		T336	398		9		0		0		0		0		0		0		0	
		T340	392		14		1		0		0		0		0		1		1	
		T348	358		38		9		2		0		0		0		2		1	
		T350	370		27		7		3		0		0		0		1		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NEW JERSEY	245	F015	238	97	6	2	1	0	0	0	0	0	0	0	0	0	1	0	4	2
		F062	243	99	2	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		F070	243	99	2	1	0	0	0	0	0	0	0	0	2	1	0	0	0	0
		F071	238	97	7	3	0	0	0	0	0	0	3	1	2	1	1	0	1	0
		F073	238	97	7	3	0	0	0	0	0	0	1	0	4	2	0	0	1	0
		F101	242	99	3	1	0	0	0	0	0	0	0	0	2	1	0	0	1	0
		F105	233	95	11	4	1	0	0	0	0	0	3	1	2	1	0	0	6	2
		F111	180	73	50	20	15	6	0	0	0	0	13	5	20	8	17	7	16	7
		F112	132	54	55	22	35	14	17	7	6	2	23	9	59	24	44	18	50	20
		F123	209	85	28	11	7	3	1	0	0	0	8	3	9	4	11	4	10	4
		F134	216	88	25	10	4	2	0	0	0	0	3	1	7	3	11	4	6	2
		F135	215	88	24	10	6	2	0	0	0	0	5	2	10	4	6	2	6	2
		F136	41	17	56	23	57	23	51	21	40	16	89	36	131	53	92	38	110	45
		F173	213	87	25	10	7	3	0	0	0	0	6	2	16	7	6	2	4	2
		F175	180	73	51	21	11	4	2	1	1	0	20	8	27	11	14	6	9	4
		F176	94	38	80	33	44	18	21	9	6	2	41	17	76	31	46	19	58	24
		F177	221	90	24	10	0	0	0	0	0	0	7	3	7	3	3	1	4	2
		F178	154	63	71	29	17	7	3	1	0	0	26	11	35	14	15	6	20	8
		F180	177	72	47	19	16	7	5	2	0	0	21	9	21	9	22	9	16	7
		F181	233	95	11	4	1	0	0	0	0	0	1	0	2	1	0	0	5	2
		F182	242	99	3	1	0	0	0	0	0	0	1	0	0	0	0	0	2	1
		F186	72	29	91	37	53	22	25	10	4	2	40	16	74	30	54	22	76	31
		F189	183	75	53	22	7	3	2	1	0	0	14	6	17	7	15	6	16	7
		F190	49	20	68	28	60	24	45	18	23	9	84	34	104	42	73	30	97	40
		F191	168	69	64	26	12	5	1	0	0	0	9	4	28	11	15	6	26	11
		F609	240		5		0		0		0		4		1		0		0	
		F636	236		9		0		0		0		6		1		0		0	
		F640	243		2		0		0		0		1		1		0		0	
		F648	233		12		0		0		0		7		4		0		0	
		F650	211		33		1		0		0		26		6		0		0	
	142	T094	135	0	5	4	2	1	0	0	0	0	2	1	2	1	1	1	4	3
		T095	131	0	8	6	2	1	1	1	0	0	0	0	6	4	0	0	5	4
		T103	136	0	5	4	1	1	0	0	0	0	1	1	1	1	0	0	4	3
		T105	132	0	8	6	2	1	0	0	0	0	2	1	3	2	2	1	3	2
		T117	127	0	4	3	2	1	3	2	6	4	3	2	12	8	11	8	7	5
		T118	138	0	3	2	1	1	0	0	0	0	0	0	0	0	2	1	0	0
		T127	128	0	10	7	2	1	2	1	0	0	1	1	4	3	4	3	5	4
		T129	131	0	5	4	2	1	4	3	0	0	1	1	7	5	5	4	4	3
		T135	141	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		T139	136	0	4	3	2	1	0	0	0	0	3	2	1	1	1	1	1	1
		T143	139	0	3	2	0	0	0	0	0	0	0	0	1	1	1	1	1	1
		T144	138	0	4	3	0	0	0	0	0	0	0	0	1	1	2	1	0	0
		T152	140	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T163	139	0	3	2	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		T164	140	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		T165	138	0	3	2	1	1	0	0	0	0	1	1	0	0	0	0	0	0
		T169	141	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
		T309	141		1		0		0		0		0		0		0		0	
		T336	136		6		0		0		0		0		0		0		0	
		T340	132		9		1		0		0		0		0		1		0	
		T348	102		29		9		2		0		0		0		2		0	
		T350	106		26		7		3		0		0		0		1		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NEW YORK	558	P015	479	86	68	12	8	1	3	1	0	0	10	2	30	5	28	5	17	3
		P062	426	76	97	17	25	4	10	2	0	0	32	6	50	9	62	11	25	4
		P070	498	89	57	10	3	1	0	0	0	0	3	1	10	2	17	3	22	4
		P071	525	94	29	5	4	1	0	0	0	0	8	1	11	2	10	2	4	1
		P073	513	92	42	8	2	0	1	0	0	0	6	1	9	2	18	3	9	2
		P101	536	96	20	4	2	0	0	0	0	0	5	1	9	2	5	1	4	1
		P105	443	79	100	18	13	2	2	0	0	0	26	5	50	9	36	6	15	3
		P111	447	80	97	17	10	2	4	1	0	0	21	4	47	8	27	5	15	3
		P112	452	81	97	17	6	1	3	1	0	0	20	4	35	6	20	4	13	2
		P123	485	87	63	11	9	2	1	0	0	0	4	1	22	4	27	5	26	5
		P134	491	88	58	10	8	1	1	0	0	0	4	1	15	3	23	4	27	5
		P135	506	91	44	8	8	1	0	0	0	0	5	1	9	2	17	3	21	4
		P136	456	82	84	15	15	3	3	1	0	0	5	1	16	3	26	5	33	6
		P173	379	68	132	24	42	8	3	1	2	0	29	5	48	9	61	11	76	14
		P175	377	68	130	23	41	7	9	2	1	0	32	6	43	8	60	11	82	15
		P176	367	66	134	24	50	9	5	1	2	0	33	6	46	8	57	10	84	15
		P177	402	72	127	23	27	5	2	0	0	0	36	6	55	10	56	10	33	6
		P178	392	70	124	22	39	7	3	1	0	0	35	6	55	10	56	10	44	8
		P180	442	79	97	17	18	3	1	0	0	0	21	4	34	6	47	8	23	4
		P181	439	79	100	18	18	3	0	0	1	0	23	4	43	8	38	7	29	5
		P182	515	92	35	6	7	1	1	0	0	0	8	1	17	3	16	3	5	1
		P186	441	79	93	17	22	4	1	0	1	0	19	3	37	7	34	6	34	6
		P189	352	63	154	28	39	7	12	2	1	0	38	7	93	17	76	14	52	9
		P190	340	61	154	28	50	9	11	2	3	1	43	8	92	16	75	14	56	10
		P191	481	86	69	12	8	1	0	0	0	0	13	2	27	5	25	4	8	1
	265	T094	244	92	17	6	4	2	0	0	0	0	4	2	5	2	4	2	3	1
		T095	234	88	27	10	2	1	2	1	0	0	1	0	7	3	10	4	8	3
		T103	193	73	47	18	19	7	6	2	0	0	8	3	30	11	31	12	29	11
		T105	233	88	26	10	6	2	0	0	0	0	2	1	10	4	9	3	14	5
		T117	158	60	70	26	29	11	7	3	1	0	12	5	35	13	29	11	26	10
		T118	259	98	5	2	1	0	0	0	0	0	0	0	0	0	5	2	2	1
		T127	244	92	21	8	0	0	0	0	0	0	0	0	9	3	5	2	4	2
		T129	218	82	43	16	4	2	0	0	0	0	6	2	12	5	15	6	10	4
		T135	241	91	23	9	1	0	0	0	0	0	0	0	8	3	7	3	6	2
		T139	246	93	18	7	1	0	0	0	0	0	0	0	1	0	3	1	6	2
		T143	250	94	14	5	1	0	0	0	0	0	0	0	4	2	3	1	2	1
		T144	251	95	14	5	0	0	0	0	0	0	0	0	2	1	1	0	3	1
		T152	243	92	17	6	5	2	0	0	0	0	1	0	8	3	8	3	9	3
		T163	245	92	17	6	3	1	0	0	0	0	0	0	6	2	7	3	0	0
		T164	264	100	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T165	242	91	20	8	3	1	0	0	0	0	3	1	10	4	8	3	4	2
		T169	261	98	4	2	0	0	0	0	0	0	0	0	1	0	1	0	1	0
		T336	262		3		0		0		0		0		0		0		0	
		T340	260		5		0		0		0		0		0		0		1	
		T348	256		9		0		0		0		0		0		0		1	
		T350	264		1		0		0		0		0		0		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
PUERTO RICO	4	P135	1	25	2	50	1	25	0	0	0	0	0	0	3	75	0	0	0	0
		P136	3	75	1	25	0	0	0	0	0	0	1	25	0	0	0	0	0	0
		P175	1	25	2	50	1	25	0	0	0	0	1	25	2	50	1	25	0	0
		P178	3	75	1	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 03	848	P015	828	98	19	2	1	0	0	0	0	0	5	1	6	1	5	1	2	0
		P062	839	99	8	1	1	0	0	0	0	0	3	0	2	0	3	0	1	0
		P070	833	98	15	2	0	0	0	0	0	0	6	1	4	0	2	0	2	0
		P071	841	99	7	1	0	0	0	0	0	0	2	0	3	0	0	0	1	0
		P073	664	78	151	18	27	3	6	1	0	0	74	9	54	6	33	4	43	5
		P101	843	99	5	1	0	0	0	0	0	0	1	0	0	0	2	0	0	0
		P105	832	98	16	2	0	0	0	0	0	0	2	0	5	1	5	1	1	0
		P111	592	70	179	21	63	7	14	2	0	0	92	11	91	11	75	9	59	7
		P112	605	71	186	22	47	6	7	1	3	0	75	9	91	11	75	9	43	5
		P123	804	95	40	5	4	0	0	0	0	0	8	1	13	2	10	1	5	1
		P134	771	91	69	8	8	1	0	0	0	0	20	2	24	3	20	2	13	2
		P135	684	81	133	16	31	4	0	0	0	0	40	5	51	6	46	5	36	4
		P136	519	61	208	25	89	10	28	3	4	0	135	16	126	15	114	13	69	8
		P173	792	93	52	6	4	0	0	0	0	0	14	2	11	1	18	2	10	1
		P175	719	85	108	13	19	2	2	0	0	0	37	4	31	4	36	4	29	3
		P176	684	81	124	15	31	4	9	1	0	0	47	6	61	7	45	5	33	4
		P177	810	96	36	4	2	0	0	0	0	0	15	2	4	0	17	2	2	0
		P178	702	83	108	13	31	4	7	1	0	0	63	7	52	6	39	5	22	3
		P180	706	83	120	14	20	2	2	0	0	0	56	7	38	4	47	6	14	2
		P181	839	99	8	1	1	0	0	0	0	0	2	0	5	1	1	0	1	0
		P182	811	96	34	4	3	0	0	0	0	0	7	1	7	1	8	1	15	2
		P186	673	79	138	16	28	3	8	1	1	0	61	7	69	8	45	5	28	3
		P189	824	97	21	2	3	0	0	0	0	0	5	1	9	1	6	1	1	0
		P190	593	70	182	21	58	7	14	2	1	0	81	10	88	10	84	10	54	6
		P191	765	90	73	9	8	1	2	0	0	0	19	2	32	4	16	2	18	2
		P609	838		10		0		0		0		9		1		0		0	
		P636	819		29		0		0		0		26		3		0		0	
		P640	782		65		1		0		0		61		5		1		0	
		P648	830		18		0		0		0		12		5		0		0	
		P650	803		45		0		0		0		40		5		0		0	
	580	T094	455	78	106	18	15	3	3	1	1	0	24	4	44	8	25	4	40	7
		T095	444	77	111	19	16	3	9	2	0	0	48	8	60	10	30	5	24	4
		T103	501	86	62	11	14	2	2	0	1	0	20	3	29	5	27	5	15	3
		T105	442	76	102	18	23	4	12	2	1	0	44	8	67	12	31	5	36	6
		T117	336	58	137	24	64	11	35	6	8	1	76	13	129	22	78	13	78	13
		T118	545	94	31	5	4	1	0	0	0	0	13	2	8	1	7	1	10	2
		T127	534	92	45	8	1	0	0	0	0	0	10	2	9	2	13	2	10	2
		T129	520	90	51	9	6	1	3	1	0	0	13	2	15	3	19	3	15	3
		T135	552	95	26	4	2	0	0	0	0	0	4	1	9	2	6	1	8	1
		T139	389	67	124	21	52	9	12	2	3	1	67	12	91	16	49	8	47	8
		T143	427	74	105	18	40	7	6	1	2	0	39	7	66	11	50	9	27	5
		T144	469	81	92	16	16	3	3	1	0	0	29	5	50	9	26	4	21	4
		T152	519	89	52	9	7	1	2	0	0	0	7	1	30	5	13	2	16	3
		T163	458	79	92	16	24	4	5	1	1	0	28	5	52	9	43	7	28	5
		T164	536	92	37	6	7	1	0	0	0	0	7	1	15	3	11	2	13	2
		T165	549	95	28	5	3	1	0	0	0	0	6	1	9	2	7	1	8	1
		T169	570	98	9	2	1	0	0	0	0	0	1	0	1	0	1	0	4	1
		T309	572		7		0		1		0		0		3		3		0	
		T336	555		19		5		1		0		0		3		16		10	
		T340	527		40		11		2		0		0		13		26		15	
		T348	568		10		2		0		0		0		5		4		4	
		T350	554		24		2		0		0		0		5		15		3	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
DELAWARE	25	F062	24	96	0	0	1	4	0	0	0	0	0	0	1	4	1	4	0	0
		F073	24	96	0	0	1	4	0	0	0	0	0	0	0	0	1	4	1	4
		F111	24	96	0	0	1	4	0	0	0	0	0	0	2	8	0	0	0	0
		F112	19	76	5	20	1	4	0	0	0	0	1	4	2	8	1	4	0	0
		F123	20	80	4	16	1	4	0	0	0	0	1	4	1	4	0	0	2	8
		F134	20	80	4	16	1	4	0	0	0	0	0	0	0	0	1	4	4	16
		F135	18	72	5	20	2	8	0	0	0	0	1	4	2	8	1	4	4	16
		F136	22	88	3	12	0	0	0	0	0	0	0	0	1	4	2	8	0	0
		F175	23	92	2	8	0	0	0	0	0	0	1	4	1	4	0	0	0	0
		F176	22	88	3	12	0	0	0	0	0	0	2	8	1	4	0	0	0	0
		F180	24	96	1	4	0	0	0	0	0	0	0	0	1	4	0	0	0	0
		F181	23	92	2	8	0	0	0	0	0	0	0	0	2	8	0	0	0	0
		F186	15	60	4	16	5	20	1	4	0	0	4	16	5	20	1	4	4	16
		F189	22	88	3	12	0	0	0	0	0	0	0	0	2	8	0	0	0	0
		F190	16	64	6	24	3	12	0	0	0	0	3	12	4	16	1	4	2	8
		F191	20	80	4	16	1	4	0	0	0	0	0	0	3	12	1	4	1	4
		F640	24		1		0		0		0		0		0		1		0	
	20	T094	17	85	3	15	0	0	0	0	0	0	0	0	0	0	1	5	1	5
		T095	18	90	2	10	0	0	0	0	0	0	0	0	1	5	1	5	0	0
		T103	16	80	3	15	1	5	0	0	0	0	0	0	0	0	1	5	3	15
		T105	18	90	1	5	1	5	0	0	0	0	0	0	1	5	1	5	1	5
		T117	17	85	2	10	0	0	0	0	1	5	1	5	3	15	0	0	2	10
		T129	19	95	0	0	1	5	0	0	0	0	1	5	1	5	0	0	0	0
		T139	17	85	3	15	0	0	0	0	0	0	0	0	0	0	0	0	3	15
		T143	17	85	2	10	1	5	0	0	0	0	0	0	1	5	1	5	1	5
		T144	19	95	0	0	0	0	1	5	0	0	1	5	1	5	1	5	0	0
		T152	19	95	1	5	0	0	0	0	0	0	0	0	0	0	0	0	1	5
		T163	18	90	2	10	0	0	0	0	0	0	0	0	1	5	1	5	0	0
		T165	18	90	2	10	0	0	0	0	0	0	0	0	1	5	0	0	1	5
		T169	18	90	2	10	0	0	0	0	0	0	0	0	0	0	1	5	1	5
		T309	19		1		0		0		0		0		1		0		0	
		T348	19		1		0		0		0		0		1		0		0	

STATE	FACIL CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
WASHINGTON D.C.	8 F062	6	75	2	25	0	0	0	0	0	0	1	13	1	13	0	0	0	0
	F073	5	63	3	38	0	0	0	0	0	0	1	13	0	0	1	13	1	13
	F105	5	63	3	38	0	0	0	0	0	0	0	0	1	13	1	13	0	0
	F111	4	50	4	50	0	0	0	0	0	0	1	13	2	25	0	0	1	13
	F112	5	63	2	25	0	0	1	13	0	0	1	13	2	25	1	13	1	13
	F123	5	63	3	38	0	0	0	0	0	0	0	0	2	25	0	0	0	0
	F134	5	63	2	25	1	13	0	0	0	0	1	13	1	13	1	13	0	0
	F135	2	25	5	63	1	13	0	0	0	0	2	25	2	25	1	13	1	13
	F136	3	38	1	13	3	38	1	13	0	0	0	0	3	38	2	25	4	50
	F173	5	63	3	38	0	0	0	0	0	0	1	13	1	13	0	0	0	0
	F175	5	63	3	38	0	0	0	0	0	0	1	13	1	13	0	0	0	0
	F176	3	38	3	38	2	25	0	0	0	0	1	13	3	38	0	0	2	25
	F177	6	75	2	25	0	0	0	0	0	0	1	13	0	0	0	0	0	0
	F178	5	63	3	38	0	0	0	0	0	0	1	13	1	13	0	0	0	0
	F180	4	50	4	50	0	0	0	0	0	0	1	13	2	25	0	0	0	0
	F181	6	75	2	25	0	0	0	0	0	0	0	0	1	13	0	0	1	13
	F186	6	75	1	13	1	13	0	0	0	0	2	25	1	13	0	0	0	0
	F189	7	88	1	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	F190	5	63	3	38	0	0	0	0	0	0	1	13	1	13	0	0	0	0
	F191	5	63	3	38	0	0	0	0	0	0	0	0	0	0	0	0	2	25
	F636	7		1		0		0		0		0		1		0		0	
	7 T094	1	14	2	29	2	29	1	14	1	14	2	29	2	29	3	43	5	71
	T095	0	0	3	43	1	14	3	43	0	0	0	0	3	43	5	71	5	71
	T103	2	29	1	14	1	14	2	29	1	14	2	29	3	43	3	43	3	43
	T105	0	0	3	43	2	29	2	29	0	0	2	29	5	71	3	43	2	29
	T117	0	0	5	71	2	29	0	0	0	0	2	29	2	29	1	14	3	43
	T118	5	71	2	29	0	0	0	0	0	0	0	0	1	14	1	14	0	0
	T127	3	43	4	57	0	0	0	0	0	0	0	0	1	14	0	0	2	29
	T129	1	14	5	71	0	0	1	14	0	0	1	14	2	29	2	29	2	29
	T139	0	0	3	43	2	29	2	29	0	0	4	57	3	43	2	29	3	43
	T143	4	57	2	29	1	14	0	0	0	0	1	14	3	43	0	0	0	0
	T144	2	29	3	43	2	29	0	0	0	0	2	29	4	57	1	14	0	0
	T152	3	43	4	57	0	0	0	0	0	0	0	0	1	14	2	29	0	0
	T163	5	71	2	29	0	0	0	0	0	0	1	14	0	0	0	0	0	0
	T164	4	57	2	29	1	14	0	0	0	0	1	14	1	14	1	14	0	0
	T165	4	57	2	29	1	14	0	0	0	0	0	0	0	0	1	14	2	29
	T169	6	86	0	0	1	14	0	0	0	0	0	0	1	14	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MARYLAND	116	F015	115	99	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
		F062	115	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		F070	112	97	4	3	0	0	0	0	0	0	2	2	1	1	0	0	1	1
		F071	114	98	2	2	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		F073	87	75	27	23	2	2	0	0	0	0	22	19	5	4	1	1	3	3
		F105	110	95	6	5	0	0	0	0	0	0	0	0	3	3	2	2	0	0
		F111	79	68	30	26	6	5	1	1	0	0	5	4	16	14	11	9	12	10
		F112	71	61	37	32	8	7	0	0	0	0	6	5	23	20	13	11	9	8
		F123	110	95	6	5	0	0	0	0	0	0	2	2	2	2	1	1	0	0
		F134	92	79	21	18	3	3	0	0	0	0	8	7	12	10	6	5	0	0
		F135	100	86	14	12	2	2	0	0	0	0	4	3	8	7	4	3	0	0
		F136	32	28	43	37	28	24	13	11	0	0	36	31	49	42	35	30	11	9
		F173	96	83	17	15	3	3	0	0	0	0	5	4	7	6	8	7	1	1
		F175	84	72	27	23	5	4	0	0	0	0	9	8	15	13	9	8	1	1
		F176	79	68	32	28	4	3	1	1	0	0	11	9	16	14	9	8	3	3
		F177	95	82	19	16	2	2	0	0	0	0	6	5	4	3	11	9	2	2
		F178	48	41	42	36	20	17	6	5	0	0	33	28	34	29	24	21	5	4
		F180	64	55	41	35	10	9	1	1	0	0	20	17	20	17	23	20	0	0
		F181	115	99	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		F182	109	94	7	6	0	0	0	0	0	0	1	1	3	3	3	3	0	0
		F186	79	68	33	28	3	3	1	1	0	0	10	9	14	12	12	10	3	3
		F189	109	94	7	6	0	0	0	0	0	0	0	0	2	2	3	3	1	1
		F190	67	58	37	32	7	6	5	4	0	0	11	9	15	13	21	18	17	15
		F191	100	86	14	12	2	2	0	0	0	0	3	3	3	3	5	4	6	5
		F636	110		6		0		0		0		5		1		0		0	
		F640	90		26		0		0		0		22		4		0		0	
		F648	110		6		0		0		0		4		1		0		0	
		F650	105		11		0		0		0		9		2		0		0	
	88	T094	71	81	11	13	5	6	1	1	0	0	10	11	6	7	7	8	1	1
		T095	33	38	42	48	9	10	4	5	0	0	31	35	22	25	15	17	2	2
		T103	66	75	15	17	7	8	0	0	0	0	9	10	6	7	11	13	1	1
		T105	65	74	18	20	3	3	2	2	0	0	8	9	12	14	8	9	2	2
		T117	46	52	31	35	9	10	2	2	0	0	14	16	19	22	13	15	7	8
		T118	76	86	10	11	2	2	0	0	0	0	3	3	3	3	3	3	4	5
		T127	74	84	14	16	0	0	0	0	0	0	0	0	2	2	8	9	3	3
		T129	82	93	5	6	0	0	1	1	0	0	1	1	1	1	3	3	3	3
		T135	78	89	10	11	0	0	0	0	0	0	0	0	2	2	6	7	2	2
		T139	34	39	28	32	23	26	3	3	0	0	24	27	37	42	18	20	4	5
		T143	71	81	14	16	3	3	0	0	0	0	1	1	6	7	10	11	2	2
		T144	74	84	13	15	1	1	0	0	0	0	1	1	11	13	2	2	1	1
		T152	86	98	2	2	0	0	0	0	0	0	1	1	0	0	1	1	0	0
		T163	65	74	18	20	4	5	1	1	0	0	5	6	9	10	11	13	2	2
		T164	80	91	6	7	2	2	0	0	0	0	1	1	3	3	3	3	1	1
		T165	79	90	9	10	0	0	0	0	0	0	4	5	3	3	1	1	0	0
		T169	87	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T340	83		4		1		0		0		0		3		1		0	
		T348	86		1		1		0		0		0		2		0		0	
		T350	85		3		0		0		0		0		0		3		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
PENNSYLVANIA	579	P015	568	98	11	2	0	0	0	0	0	0	4	1	3	1	2	0	2	0
		P062	576	99	3	1	0	0	0	0	0	0	1	0	0	0	1	0	1	0
		P070	576	99	3	1	0	0	0	0	0	0	0	0	1	0	1	0	1	0
		P071	577	100	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		P073	486	84	82	14	8	1	3	1	0	0	26	4	21	4	23	4	29	5
		P101	577	100	2	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0
		P105	574	99	5	1	0	0	0	0	0	0	2	0	1	0	2	0	0	0
		P111	390	67	124	21	52	9	13	2	0	0	82	14	66	11	56	10	41	7
		P112	427	74	111	19	32	6	6	1	3	1	55	9	52	9	56	10	29	5
		P123	569	98	10	2	0	0	0	0	0	0	4	1	1	0	2	0	2	0
		P134	553	96	25	4	1	0	0	0	0	0	8	1	6	1	6	1	6	1
		P135	478	83	79	14	22	4	0	0	0	0	25	4	31	5	32	6	26	4
		P136	392	68	129	22	43	7	12	2	3	1	80	14	54	9	63	11	46	8
		P173	550	95	28	5	1	0	0	0	0	0	7	1	3	1	10	2	9	2
		P175	500	86	66	11	11	2	2	0	0	0	22	4	13	2	23	4	26	4
		P176	482	83	68	12	21	4	8	1	0	0	30	5	36	6	29	5	25	4
		P177	570	98	9	2	0	0	0	0	0	0	6	1	0	0	3	1	0	0
		P178	526	91	46	8	6	1	1	0	0	0	21	4	11	2	9	2	14	2
		P180	513	89	58	10	7	1	1	0	0	0	25	4	14	2	21	4	11	2
		P181	578	100	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
		P182	551	95	25	4	3	1	0	0	0	0	5	1	4	1	5	1	15	3
		P186	489	84	72	12	14	2	3	1	1	0	37	6	38	7	20	3	13	2
		P189	574	99	5	1	0	0	0	0	0	0	2	0	2	0	0	0	0	0
		P190	427	74	114	20	33	6	5	1	0	0	49	8	56	10	47	8	30	5
		P191	545	94	33	6	1	0	0	0	0	0	10	2	14	2	4	1	6	1
		P609	571		8		0		0		0		8		0		0		0	
		P636	557		22		0		0		0		21		1		0		0	
		P640	542		36		1		0		0		37		1		0		0	
		P648	573		6		0		0		0		5		1		0		0	
		P650	553		26		0		0		0		26		0		0		0	
	296	T094	251	85	44	15	1	0	0	0	0	0	8	3	30	10	3	1	4	1
		T095	259	88	34	11	2	1	1	0	0	0	9	3	25	8	2	1	3	1
		T103	284	96	11	4	1	0	0	0	0	0	3	1	7	2	0	0	1	0
		T105	276	93	19	6	1	0	0	0	0	0	4	1	13	4	2	1	2	1
		T117	243	82	45	15	6	2	2	1	0	0	16	5	27	9	5	2	7	2
		T118	288	97	7	2	1	0	0	0	0	0	5	2	3	1	1	0	0	0
		T127	286	97	10	3	0	0	0	0	0	0	5	2	3	1	0	0	1	0
		T129	290	98	6	2	0	0	0	0	0	0	1	0	2	1	0	0	2	1
		T135	291	98	4	1	1	0	0	0	0	0	1	0	4	1	0	0	1	0
		T139	254	86	38	13	3	1	1	0	0	0	13	4	18	6	2	1	7	2
		T143	271	92	21	7	3	1	1	0	0	0	6	2	18	6	4	1	1	0
		T144	272	92	22	7	2	1	0	0	0	0	5	2	15	5	3	1	2	1
		T152	277	94	18	6	1	0	0	0	0	0	5	2	11	4	3	1	1	0
		T183	280	95	16	5	0	0	0	0	0	0	1	0	13	4	0	0	1	0
		T164	284	96	11	4	1	0	0	0	0	0	5	2	6	2	0	0	1	0
		T165	291	98	5	2	0	0	0	0	0	0	1	0	2	1	1	0	0	0
		T169	293	99	3	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0
		T309	289		6		0		1		0		0		2		3		0	
		T336	271		19		5		1		0		0		3		16		10	
		T340	249		36		10		1		0		0		9		25		13	
		T348	288		7		1		0		0		0		1		4		4	
		T350	274		20		2		0		0		0		4		12		3	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
VIRGINIA	79	F015	75	95	4	5	0	0	0	0	0	0	1	1	0	0	1	1	0	0
		F062	77	97	2	3	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		F070	76	96	3	4	0	0	0	0	0	0	0	0	2	3	1	1	0	0
		F071	78	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F073	46	58	25	32	7	9	1	1	0	0	10	13	16	20	5	6	7	9
		F101	76	96	3	4	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		F105	78	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F111	63	80	13	16	3	4	0	0	0	0	1	1	3	4	4	5	5	6
		F112	64	81	14	18	1	1	0	0	0	0	2	3	6	8	1	1	3	4
		F123	67	85	11	14	1	1	0	0	0	0	1	1	4	5	3	4	1	1
		F134	70	89	8	10	1	1	0	0	0	0	0	0	2	3	3	4	3	4
		F135	64	81	14	18	1	1	0	0	0	0	2	3	5	6	3	4	3	4
		F136	56	71	19	24	3	4	1	1	0	0	11	14	5	6	6	8	4	5
		F173	78	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F175	70	89	7	9	2	3	0	0	0	0	3	4	0	0	3	4	2	3
		F176	69	87	8	10	2	3	0	0	0	0	1	1	3	4	2	3	3	4
		F177	76	96	3	4	0	0	0	0	0	0	1	1	0	0	1	1	0	0
		F178	66	84	12	15	1	1	0	0	0	0	4	5	1	1	2	3	3	4
		F180	67	85	11	14	1	1	0	0	0	0	4	5	0	0	3	4	3	4
		F182	78	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		F186	65	82	11	14	2	3	1	1	0	0	1	1	3	4	6	8	5	6
		F190	64	81	10	13	4	5	1	1	0	0	6	8	3	4	5	6	2	3
		F191	70	89	9	11	0	0	0	0	0	0	1	1	6	8	1	1	0	0
	117	T094	78	67	37	32	2	2	0	0	0	0	0	0	2	2	2	2	26	22
		T095	105	90	12	10	0	0	0	0	0	0	0	0	4	3	1	1	4	3
		T103	105	90	12	10	0	0	0	0	0	0	0	0	3	3	5	4	2	2
		T105	65	56	39	33	8	7	4	3	1	1	15	13	19	16	12	10	21	18
		T117	13	11	36	31	33	28	28	24	7	6	33	28	62	53	48	41	48	41
		T118	111	95	6	5	0	0	0	0	0	0	0	0	1	1	0	0	5	4
		T127	108	92	9	8	0	0	0	0	0	0	2	2	1	1	2	2	3	3
		T129	92	79	22	19	2	2	1	1	0	0	6	5	6	5	4	3	6	5
		T135	114	97	3	3	0	0	0	0	0	0	0	0	2	2	0	0	1	1
		T139	68	58	34	29	11	9	2	2	2	2	10	9	19	16	15	13	18	15
		T143	47	40	42	36	22	19	4	3	2	2	23	20	28	24	18	15	17	15
		T144	73	62	37	32	6	5	1	1	0	0	10	9	13	11	9	8	14	12
		T152	89	76	21	18	5	4	2	2	0	0	1	1	16	14	5	4	11	9
		T163	52	44	44	38	18	15	2	2	1	1	19	16	25	21	23	20	20	17
		T164	103	88	12	10	2	2	0	0	0	0	0	0	4	3	4	3	7	6
		T165	112	96	5	4	0	0	0	0	0	0	1	1	0	0	0	0	3	3
		T169	114	97	3	3	0	0	0	0	0	0	0	0	0	0	0	0	2	2

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
WEST VIRGINIA	41	F015	37	90	3	7	1	2	0	0	0	0	0	0	2	5	2	5	0	0
		F070	36	88	5	12	0	0	0	0	0	0	4	10	0	0	0	0	0	0
		F071	39	95	2	5	0	0	0	0	0	0	1	2	1	2	0	0	0	0
		F073	16	39	14	34	9	22	2	5	0	0	15	37	12	29	2	5	2	5
		F105	40	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F111	32	78	8	20	1	2	0	0	0	0	3	7	2	5	4	10	0	0
		F112	19	46	17	41	5	12	0	0	0	0	10	24	6	15	3	7	1	2
		F123	33	80	6	15	2	5	0	0	0	0	0	0	3	7	4	10	0	0
		F134	31	76	9	22	1	2	0	0	0	0	3	7	3	7	3	7	0	0
		F135	22	54	16	39	3	7	0	0	0	0	6	15	3	7	5	12	2	5
		F136	14	34	13	32	12	29	1	2	1	2	8	20	14	34	6	15	4	10
		F173	38	93	3	7	0	0	0	0	0	0	1	2	0	0	0	0	0	0
		F175	37	90	3	7	1	2	0	0	0	0	1	2	1	2	1	2	0	0
		F176	29	71	10	24	2	5	0	0	0	0	2	5	2	5	5	12	0	0
		F177	38	93	3	7	0	0	0	0	0	0	1	2	0	0	2	5	0	0
		F178	32	78	5	12	4	10	0	0	0	0	4	10	5	12	4	10	0	0
		F180	34	83	5	12	2	5	0	0	0	0	6	15	1	2	0	0	0	0
		F181	38	93	2	5	1	2	0	0	0	0	1	2	2	5	0	0	0	0
		F182	40	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F186	19	46	17	41	3	7	2	5	0	0	7	17	8	20	6	15	3	7
		F189	33	80	5	12	3	7	0	0	0	0	3	7	3	7	3	7	0	0
		F190	14	34	12	29	11	27	3	7	1	2	11	27	9	22	10	24	3	7
		F191	25	61	10	24	4	10	2	5	0	0	5	12	6	15	5	12	3	7
		F609	39		2		0		0		0		1		1		0		0	
		F640	39		2		0		0		0		2		0		0		0	
		F648	35		6		0		0		0		3		3		0		0	
		F650	33		8		0		0		0		5		3		0		0	
	52	T094	37	71	9	17	5	10	1	2	0	0	4	8	4	8	9	17	3	6
		T095	29	56	18	35	4	8	1	2	0	0	8	15	5	10	6	12	10	19
		T103	28	54	20	38	4	8	0	0	0	0	6	12	10	19	7	13	5	10
		T105	18	35	22	42	8	15	4	8	0	0	15	29	17	33	5	10	8	15
		T117	17	33	18	35	14	27	3	6	0	0	10	19	16	31	11	21	11	21
		T118	45	87	6	12	1	2	0	0	0	0	5	10	0	0	2	4	1	2
		T127	43	83	8	15	1	2	0	0	0	0	3	6	2	4	3	6	1	2
		T129	36	69	13	25	3	6	0	0	0	0	3	6	3	6	10	19	2	4
		T135	42	81	9	17	1	2	0	0	0	0	3	6	1	2	0	0	4	8
		T139	16	31	18	35	13	25	4	8	1	2	16	31	14	27	12	23	12	23
		T143	17	33	24	46	10	19	1	2	0	0	8	15	10	19	17	33	6	12
		T144	29	56	17	33	5	10	1	2	0	0	10	19	6	12	10	19	4	8
		T152	45	87	6	12	1	2	0	0	0	0	0	0	2	4	2	4	3	6
		T163	38	73	10	19	2	4	2	4	0	0	2	4	4	8	8	15	5	10
		T164	45	87	6	12	1	2	0	0	0	0	0	0	1	2	3	6	4	8
		T165	45	87	5	10	2	4	0	0	0	0	0	0	3	6	4	8	2	4
		T340	51		0		0		1		0		0		1		0		2	
		T348	51		1		0		0		0		0		1		0		0	
		T350	51		1		0		0		0		0		1		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 04	1474	P015	1396	95	67	5	10	1	1	0	0	0	14	1	33	2	21	1	15	1
		P062	1420	96	48	3	6	0	0	0	0	0	10	1	17	1	20	1	8	1
		P070	1416	96	50	3	7	0	1	0	0	0	16	1	25	2	19	1	5	0
		P071	1465	99	9	1	0	0	0	0	0	0	5	0	0	0	2	0	1	0
		P073	962	65	340	23	128	9	37	3	7	0	181	12	207	14	153	10	144	10
		P101	1452	99	22	1	0	0	0	0	0	0	3	0	2	0	10	1	6	0
		P105	1416	96	53	4	5	0	0	0	0	0	13	1	16	1	22	1	10	1
		P111	1238	84	200	14	32	2	3	0	1	0	50	3	77	5	72	5	57	4
		P112	1143	78	248	17	69	5	12	1	2	0	95	6	105	7	108	7	81	5
		P123	1270	86	179	12	23	2	2	0	0	0	31	2	90	6	52	4	47	3
		P134	1105	75	274	19	74	5	18	1	3	0	92	6	137	9	131	9	96	7
		P135	1001	68	337	23	111	8	21	1	4	0	127	9	157	11	175	12	131	9
		P136	751	51	399	27	207	14	86	6	31	2	290	20	341	23	282	19	224	15
		P173	1213	82	211	14	42	3	7	0	1	0	73	5	92	6	72	5	72	5
		P175	1013	69	351	24	86	6	20	1	4	0	141	10	161	11	146	10	132	9
		P176	816	55	429	29	161	11	53	4	15	1	237	16	260	18	226	15	181	12
		P177	1240	84	189	13	34	2	11	1	0	0	85	6	104	7	56	4	35	2
		P178	1005	68	332	23	102	7	31	2	4	0	182	12	204	14	140	9	95	6
		P180	991	67	337	23	103	7	39	3	4	0	168	11	213	14	136	9	122	8
		P181	1347	91	119	8	8	1	0	0	0	0	36	2	47	3	23	2	26	2
		P182	1382	94	89	6	3	0	0	0	0	0	15	1	27	2	24	2	22	1
		P186	826	56	427	29	157	11	58	4	6	0	187	13	284	19	221	15	179	12
		P189	1222	83	207	14	40	3	3	0	2	0	85	6	97	7	55	4	50	3
		P190	703	48	497	34	198	13	64	4	12	1	309	21	303	21	250	17	202	14
		P191	1146	78	266	18	56	4	6	0	0	0	74	5	114	8	98	7	81	5
		P609			27		0		0		0		22		5		0		0	
		P636			11		0		0		0		7		3		1		0	
		P640			24		0		0		0		16		5		2		0	
		P648			34		1		0		0		24		7		4		0	
		P650			59		1		0		0		40		12		7		0	
	450	T094	354	79	78	17	14	3	4	1	0	0	29	6	21	5	32	7	29	6
		T095	288	64	111	25	38	8	11	2	2	0	38	8	65	14	56	12	39	9
		T103	322	72	107	24	18	4	3	1	0	0	42	9	40	9	36	8	28	6
		T105	209	46	156	35	62	14	18	4	5	1	97	22	98	22	73	16	63	14
		T117	177	39	144	32	75	17	39	9	15	3	114	25	131	29	108	24	92	20
		T118	403	90	44	10	3	1	0	0	0	0	16	4	20	4	6	1	5	1
		T127	391	87	49	11	8	2	2	0	0	0	12	3	20	4	19	4	15	3
		T129	326	72	87	19	29	6	7	2	1	0	25	6	46	10	51	11	34	8
		T135	419	93	29	6	2	0	0	0	0	0	5	1	14	3	7	2	3	1
		T139	325	72	100	22	21	5	4	1	0	0	26	6	32	7	36	8	48	11
		T143	322	72	95	21	25	6	6	1	2	0	37	8	45	10	41	9	29	6
		T144	351	78	79	18	16	4	4	1	0	0	24	5	38	8	31	7	19	4
		T152	383	85	50	11	15	3	2	0	0	0	28	6	24	5	16	4	13	3
		T163	390	87	51	11	9	2	0	0	0	0	22	5	27	6	11	2	5	1
		T163	203	45	169	38	66	15	12	3	0	0	92	20	102	23	69	15	54	12
		T165	413	92	29	6	8	2	0	0	0	0	22	5	12	3	3	1	7	2
		T169	448	100	2	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
		T350			1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
ALABAMA	193	F015	186	96	6	3	1	1	0	0	0	0	1	1	3	2	3	2	0	0
		F062	189	98	4	2	0	0	0	0	0	0	0	0	2	1	2	1	0	0
		F071	192	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		F073	108	56	70	36	15	8	0	0	0	0	36	19	26	13	11	6	21	11
		F101	188	97	5	3	0	0	0	0	0	0	1	1	1	1	1	1	1	1
		F105	184	95	8	4	1	1	0	0	0	0	2	1	4	2	2	1	1	1
		F111	149	77	41	21	2	1	1	1	0	0	10	5	18	9	12	6	6	3
		F112	152	79	34	18	7	4	0	0	0	0	24	12	13	7	7	4	4	2
		F123	153	79	36	19	3	2	1	1	0	0	5	3	20	10	7	4	13	7
		F134	162	84	26	13	4	2	1	1	0	0	8	4	16	8	8	4	3	2
		F135	157	81	32	17	4	2	0	0	0	0	12	6	13	7	11	6	3	2
		F136	110	57	61	32	19	10	3	2	0	0	41	21	37	19	18	9	9	5
		F173	133	69	43	22	12	6	4	2	1	1	20	10	33	17	18	9	10	5
		F175	89	46	63	33	29	15	9	5	3	2	49	25	46	24	37	19	24	12
		F176	22	11	65	34	56	29	35	18	15	8	83	43	103	53	76	39	55	28
		F177	107	55	62	32	18	9	6	3	0	0	38	20	45	23	24	12	8	4
		F178	65	34	80	41	34	18	12	6	2	1	75	39	62	32	33	17	18	9
		F180	47	24	70	36	47	24	28	15	1	1	70	36	84	44	54	28	28	15
		F181	158	82	34	18	1	1	0	0	0	0	16	8	12	6	6	3	2	1
		F182	175	91	18	9	0	0	0	0	0	0	7	4	8	4	3	2	0	0
		F186	26	13	65	34	63	33	34	18	5	3	81	42	116	60	60	31	41	21
		F189	123	64	54	28	15	8	1	1	0	0	41	21	33	17	8	4	3	2
		F190	36	19	83	43	48	25	21	11	5	3	95	49	92	48	44	23	21	11
		F191	105	54	59	31	25	13	4	2	0	0	34	18	57	30	16	8	10	5
		F609			3		0		0		0		2		1		0		0	
		F640			4		0		0		0		3		1		0		0	
		F648			6		0		0		0		4		2		0		0	
		F650			9		0		0		0		5		4		0		0	
	18	T094	13	72	4	22	1	6	0	0	0	0	1	6	2	11	3	17	0	0
		T095	5	28	10	56	2	11	1	6	0	0	4	22	7	39	5	28	0	0
		T103	3	17	10	56	3	17	2	11	0	0	6	33	6	33	6	33	4	22
		T105	9	50	3	17	4	22	2	11	0	0	4	22	6	33	6	33	1	6
		T117	2	11	2	11	6	33	5	28	3	17	11	61	15	83	9	50	6	33
		T118	11	61	6	33	1	6	0	0	0	0	0	0	2	11	2	11	4	22
		T127	7	39	8	44	2	11	1	6	0	0	3	17	5	28	5	28	2	11
		T129	9	50	3	17	5	28	0	0	1	6	3	17	6	33	6	33	2	11
		T135	12	67	5	28	1	6	0	0	0	0	2	11	1	6	3	17	1	6
		T139	6	33	1	6	8	44	3	17	0	0	5	28	8	44	7	39	6	33
		T143	4	22	5	28	8	44	0	0	1	6	5	28	9	50	9	50	2	11
		T144	7	39	5	28	4	22	2	11	0	0	1	6	6	33	6	33	6	33
		T152	16	89	1	6	1	6	0	0	0	0	2	11	1	6	0	0	0	0
		T163	9	50	7	39	2	11	0	0	0	0	2	11	5	28	2	11	2	11
		T164	13	72	4	22	1	6	0	0	0	0	0	0	2	11	2	11	1	6

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
FLORIDA	409	F015	392	96	15	4	2	0	0	0	0	0	3	1	3	1	8	2	2	0
		F062	401	98	8	2	0	0	0	0	0	0	0	0	2	0	5	1	0	0
		F070	407	100	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
		F071	408	100	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
		F073	307	75	84	21	17	4	1	0	0	0	29	7	26	6	28	7	28	7
		F101	406	99	3	1	0	0	0	0	0	0	1	0	0	0	1	0	1	0
		F105	404	99	4	1	1	0	0	0	0	0	2	0	1	0	2	0	1	0
		F111	387	95	19	5	3	1	0	0	0	0	4	1	5	1	3	1	11	3
		F112	379	93	27	7	3	1	0	0	0	0	3	1	11	3	7	2	8	2
		F123	377	92	30	7	2	0	0	0	0	0	7	2	14	3	7	2	5	1
		F134	327	80	65	16	15	4	2	0	0	0	19	5	33	8	24	6	17	4
		F135	309	76	82	20	15	4	3	1	0	0	19	5	33	8	31	8	27	7
		F136	227	56	130	32	44	11	7	2	1	0	54	13	61	15	60	15	54	13
		F173	349	85	55	13	4	1	1	0	0	0	16	4	20	5	13	3	16	4
		F175	307	75	85	21	13	3	4	1	0	0	31	8	38	9	27	7	26	6
		F176	269	66	109	27	30	7	1	0	0	0	52	13	46	11	33	8	32	8
		F177	365	89	36	9	7	2	1	0	0	0	17	4	17	4	11	3	5	1
		F178	322	79	60	15	20	5	6	1	1	0	31	8	42	10	29	7	15	4
		F180	287	70	97	24	19	5	4	1	2	0	40	10	46	11	26	6	31	8
		F181	399	98	10	2	0	0	0	0	0	0	1	0	4	1	2	0	3	1
		F182	402	98	7	2	0	0	0	0	0	0	1	0	2	0	2	0	2	0
		F186	313	77	83	20	11	3	2	0	0	0	17	4	23	6	31	8	29	7
		F189	360	88	42	10	7	2	0	0	0	0	15	4	15	4	10	2	11	3
		F190	245	60	118	29	37	9	9	2	0	0	68	17	45	11	45	11	46	11
		F191	349	85	56	14	4	1	0	0	0	0	9	2	10	2	22	5	20	5
		F609			6		0		0		0		5		1		0		0	
		F636			7		0		0		0		4		2		1		0	
		F640			12		0		0		0		6		4		2		0	
		F648			9		1		0		0		4		3		4		0	
		F650			16		1		0		0		8		4		6		0	
	4	T103	3	75	1	25	0	0	0	0	0	0	0	0	1	25	0	0	0	0
		T117	1	25	1	25	1	25	1	25	0	0	0	0	2	50	2	50	1	25
		T152	3	75	1	25	0	0	0	0	0	0	0	0	0	0	1	25	0	0
		T163	3	75	0	0	1	25	0	0	0	0	0	0	1	25	0	0	0	0
		T165	3	75	1	25	0	0	0	0	0	0	0	0	1	25	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
GEORGIA	281	F015	267	95	12	4	2	1	0	0	0	0	1	0	7	2	2	1	3	1
		F062	253	90	22	8	6	2	0	0	0	0	8	3	8	3	9	3	7	2
		F070	280	100	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
		F073	148	53	82	29	41	15	8	3	2	1	43	15	61	22	45	16	33	12
		F101	279	99	2	1	0	0	0	0	0	0	0	0	1	0	0	0	1	0
		F105	268	95	13	5	0	0	0	0	0	0	4	1	4	1	3	1	2	1
		F111	246	88	30	11	5	2	0	0	0	0	10	4	9	3	11	4	6	2
		F112	215	77	53	19	12	4	1	0	0	0	22	8	16	6	18	6	16	6
		F123	229	81	46	16	6	2	0	0	0	0	2	1	23	8	14	5	14	5
		F134	169	60	72	26	30	11	8	3	2	1	31	11	40	14	40	14	39	14
		F135	170	60	75	27	29	10	5	2	2	1	33	12	35	12	38	14	35	12
		F136	100	36	72	26	66	23	32	11	11	4	70	25	88	31	91	32	70	25
		F173	229	81	40	14	11	4	1	0	0	0	14	5	15	5	16	6	15	5
		F175	161	57	91	32	23	8	5	2	1	0	25	9	38	14	43	15	39	14
		F176	164	58	86	31	24	9	7	2	0	0	27	10	38	14	44	16	32	11
		F177	246	88	31	11	3	1	1	0	0	0	12	4	10	4	9	3	6	2
		F178	201	72	65	23	11	4	3	1	1	0	26	9	30	11	20	7	16	6
		F180	207	74	56	20	16	6	1	0	1	0	21	7	31	11	20	7	17	6
		F181	222	79	52	19	7	2	0	0	0	0	15	5	21	7	10	4	17	6
		F182	259	92	22	8	0	0	0	0	0	0	2	1	4	1	4	1	10	4
		F186	127	45	104	37	40	14	10	4	0	0	37	13	57	20	54	19	54	19
		F189	198	70	63	22	16	6	2	1	2	1	22	8	26	9	25	9	27	10
		F190	101	36	106	38	51	18	19	7	4	1	48	17	57	20	80	28	75	27
		F191	188	67	70	25	21	7	2	1	0	0	19	7	24	9	30	11	34	12
		F609			11		0		0		0		10		1		0		0	
		F640			4		0		0		0		4		0		0		0	
		F648			4		0		0		0		3		1		0		0	
		F650			18		0		0		0		15		2		0		0	
	42	T094	37	88	5	12	0	0	0	0	0	0	1	2	1	2	1	2	2	5
		T095	29	69	7	17	6	14	0	0	0	0	4	10	2	5	6	14	4	10
		T103	28	67	11	26	3	7	0	0	0	0	2	5	6	14	3	7	5	12
		T105	20	48	15	36	6	14	1	2	0	0	9	21	4	10	6	14	8	19
		T117	23	55	12	29	6	14	0	0	1	2	8	19	6	14	8	19	4	10
		T118	39	93	3	7	0	0	0	0	0	0	0	0	1	2	1	2	0	0
		T127	33	79	8	19	1	2	0	0	0	0	2	5	0	0	2	5	5	12
		T129	29	69	10	24	2	5	1	2	0	0	5	12	3	7	3	7	5	12
		T135	41	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		T139	33	79	8	19	1	2	0	0	0	0	0	0	1	2	4	10	5	12
		T143	26	62	12	29	3	7	0	0	1	2	6	14	4	10	5	12	4	10
		T144	29	69	10	24	3	7	0	0	0	0	8	19	2	5	4	10	1	2
		T152	35	83	6	14	1	2	0	0	0	0	4	10	1	2	1	2	0	0
		T163	37	88	4	10	1	2	0	0	0	0	4	10	2	5	0	0	0	0
		T164	34	81	8	19	0	0	0	0	0	0	5	12	3	7	0	0	0	0
		T165	40	95	2	5	0	0	0	0	0	0	0	0	0	0	1	2	1	2
		T169	41	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
		T350			1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
KENTUCKY	93	F015	78	84	14	15	1	1	0	0	0	0	4	4	4	4	2	2	6	6
		F062	89	96	4	4	0	0	0	0	0	0	0	0	2	2	2	2	0	0
		F071	92	99	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		F073	86	92	7	8	0	0	0	0	0	0	0	0	3	3	3	3	0	0
		F101	91	98	2	2	0	0	0	0	0	0	0	0	0	0	2	2	0	0
		F105	90	97	3	3	0	0	0	0	0	0	0	0	0	0	2	2	1	1
		F111	84	90	8	9	1	1	0	0	0	0	1	1	6	6	2	2	1	1
		F112	81	87	12	13	0	0	0	0	0	0	6	6	3	3	3	3	0	0
		F123	67	72	22	24	3	3	1	1	0	0	7	8	9	10	8	9	5	5
		F134	65	70	22	24	6	6	0	0	0	0	4	4	10	11	11	12	6	6
		F135	71	76	22	24	0	0	0	0	0	0	3	3	6	6	4	4	6	6
		F136	56	60	28	30	6	6	2	2	1	1	9	10	17	18	12	13	10	11
		F173	65	70	21	23	7	8	0	0	0	0	5	5	10	11	10	11	9	10
		F175	63	68	23	25	7	8	0	0	0	0	6	6	10	11	10	11	11	12
		F176	63	68	22	24	6	6	2	2	0	0	7	8	9	10	12	13	10	11
		F177	84	90	9	10	0	0	0	0	0	0	2	2	3	3	0	0	4	4
		F178	76	82	15	16	2	2	0	0	0	0	5	5	7	8	2	2	5	5
		F180	82	88	11	12	0	0	0	0	0	0	1	1	4	4	0	0	6	6
		F181	89	96	4	4	0	0	0	0	0	0	1	1	2	2	0	0	1	1
		F182	88	95	5	5	0	0	0	0	0	0	1	1	0	0	4	4	0	0
		F186	73	78	17	18	3	3	0	0	0	0	7	8	6	6	3	3	7	8
		F189	79	85	14	15	0	0	0	0	0	0	2	2	8	9	3	3	1	1
		F190	67	72	21	23	5	5	0	0	0	0	11	12	12	13	5	5	3	3
		F191	90	97	3	3	0	0	0	0	0	0	0	0	1	1	0	0	2	2
	120	T094	101	84	16	13	3	3	0	0	0	0	4	3	5	4	4	3	6	5
		T095	71	59	39	33	5	4	5	4	0	0	5	4	19	16	15	13	15	13
		T103	86	72	30	25	4	3	0	0	0	0	4	3	12	10	10	8	10	8
		T105	58	48	49	41	11	9	2	2	0	0	3	3	25	21	19	16	20	17
		T117	63	53	33	28	22	18	1	1	1	1	5	4	18	15	23	19	28	23
		T118	114	95	6	5	0	0	0	0	0	0	2	2	2	2	1	1	0	0
		T127	117	98	3	3	0	0	0	0	0	0	0	0	3	3	0	0	0	0
		T129	82	68	29	24	7	6	2	2	0	0	4	3	14	12	17	14	8	7
		T135	105	88	15	13	0	0	0	0	0	0	1	1	7	6	2	2	1	1
		T139	86	72	31	26	3	3	0	0	0	0	1	1	6	5	5	4	19	16
		T143	82	68	30	25	4	3	4	3	0	0	3	3	11	9	8	7	17	14
		T144	98	82	20	17	2	2	0	0	0	0	1	1	8	7	7	6	3	3
		T152	109	91	11	9	0	0	0	0	0	0	0	0	1	1	4	3	5	4
		T163	113	94	6	5	0	0	1	1	0	0	1	1	2	2	1	1	3	3
		T164	117	98	2	2	1	1	0	0	0	0	0	0	3	3	0	0	0	0
		T165	119	99	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
		T169	119	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1933	%	1982	%
MISSISSIPPI	134	F015	129	96	5	4	0	0	0	0	0	0	0	0	3	2	1	1	1	1
		F062	129	96	5	4	0	0	0	0	0	0	1	1	2	1	1	1	1	1
		F070	81	60	45	34	7	5	1	1	0	0	16	12	24	18	18	13	3	2
		F071	130	97	4	3	0	0	0	0	0	0	2	1	0	0	0	0	1	1
		F073	19	14	38	28	47	35	26	19	4	3	41	31	66	49	53	40	56	42
		F101	130	97	4	3	0	0	0	0	0	0	0	0	0	0	2	1	2	1
		F105	127	95	7	5	0	0	0	0	0	0	0	0	2	1	2	1	3	2
		F111	92	69	36	27	6	4	0	0	0	0	6	4	7	5	12	9	16	12
		F112	64	48	42	31	21	16	6	4	1	1	12	9	14	10	34	25	33	25
		F123	116	87	14	10	4	3	0	0	0	0	1	1	5	4	8	6	6	4
		F134	88	66	34	25	9	7	3	2	0	0	8	6	16	12	21	16	13	10
		F135	43	32	49	37	34	25	8	6	0	0	22	16	28	21	45	34	35	26
		F136	8	6	35	26	41	31	34	25	16	12	55	41	88	66	71	53	59	44
		F173	122	91	11	8	1	1	0	0	0	0	2	1	3	2	5	4	3	2
		F175	100	75	29	22	4	3	1	1	0	0	6	4	14	10	10	7	10	7
		F176	42	31	65	49	23	17	4	3	0	0	30	22	35	26	28	21	23	17
		F177	127	95	7	5	0	0	0	0	0	0	2	1	3	2	0	0	2	1
		F178	78	58	41	31	14	10	1	1	0	0	13	10	16	12	20	15	21	16
		F180	102	76	26	19	6	4	0	0	0	0	6	4	10	7	9	7	13	10
		F181	129	96	5	4	0	0	0	0	0	0	2	1	1	1	1	1	1	1
		F182	130	97	4	3	0	0	0	0	0	0	0	0	3	2	0	0	1	1
		F186	43	32	67	50	14	10	9	7	1	1	15	11	36	27	36	27	27	20
		F189	129	96	5	4	0	0	0	0	0	0	1	1	1	1	0	0	3	2
		F190	52	39	57	43	21	16	2	1	2	1	13	10	39	29	28	21	22	16
		F191	91	68	41	31	2	1	0	0	0	0	3	2	12	9	13	10	10	7
		F609			7		0		0		0		5		2		0		0	
		F640			2		0		0		0		2		0		0		0	
		F648			10		0		0		0		10		0		0		0	
		F650			11		0		0		0		8		2		1		0	
	19	T094	11	58	7	37	1	5	0	0	0	0	2	11	1	5	2	11	3	16
		T095	10	53	6	32	3	16	0	0	0	0	2	11	4	21	3	16	3	16
		T103	7	37	8	42	4	21	0	0	0	0	4	21	3	16	4	21	4	21
		T105	9	47	5	26	5	26	0	0	0	0	3	16	5	26	4	21	3	16
		T117	2	11	8	42	4	21	4	21	1	5	5	26	12	63	8	42	7	37
		T118	18	95	1	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T127	11	58	6	32	2	11	0	0	0	0	2	11	2	11	3	16	2	11
		T129	13	68	3	16	3	16	0	0	0	0	1	5	2	11	2	11	2	11
		T135	18	95	1	5	0	0	0	0	0	0	1	5	0	0	0	0	0	0
		T139	7	37	10	53	2	11	0	0	0	0	4	21	2	11	4	21	3	16
		T143	14	74	4	21	1	5	0	0	0	0	0	0	1	5	4	21	1	5
		T144	15	79	4	21	0	0	0	0	0	0	0	0	2	11	2	11	0	0
		T152	12	63	3	16	4	21	0	0	0	0	2	11	5	26	4	21	0	0
		T163	7	37	5	26	7	37	0	0	0	0	1	5	7	37	5	26	5	26
		T164	12	63	4	21	3	16	0	0	0	0	3	16	1	5	6	32	0	0
		T165	16	84	3	16	0	0	0	0	0	0	0	0	0	0	1	5	2	11

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NORTH CAROLINA	175	F015	173	99	1	1	1	1	0	0	0	0	0	0	2	1	1	1	0	0
		F062	174	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F073	157	90	18	10	0	0	0	0	0	0	5	3	0	0	4	2	3	2
		F105	174	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F111	144	82	27	15	4	2	0	0	0	0	9	5	10	6	6	3	6	3
		F112	117	67	44	25	14	8	0	0	0	0	16	9	20	11	15	9	8	5
		F123	160	91	14	8	1	1	0	0	0	0	2	1	5	3	5	3	3	2
		F134	134	77	34	19	5	3	1	1	1	1	13	7	8	5	18	10	10	6
		F135	90	51	56	32	23	13	4	2	2	1	31	18	29	17	39	22	16	9
		F136	128	73	36	21	9	5	2	1	0	0	30	17	19	11	6	3	3	2
		F173	151	86	20	11	4	2	0	0	0	0	7	4	5	3	5	3	9	5
		F175	140	80	27	15	8	5	0	0	0	0	13	7	7	4	11	6	11	6
		F176	114	65	45	26	14	8	2	1	0	0	19	11	17	10	22	13	15	9
		F177	140	80	30	17	3	2	2	1	0	0	8	5	17	10	8	5	7	4
		F178	109	62	43	25	16	9	7	4	0	0	21	12	31	18	26	15	14	8
		F180	110	63	50	29	11	6	4	2	0	0	18	10	24	14	19	11	20	11
		F181	170	97	5	3	0	0	0	0	0	0	0	0	2	1	2	1	1	1
		F182	160	91	15	9	0	0	0	0	0	0	1	1	2	1	6	3	3	2
		F186	124	71	39	22	10	6	2	1	0	0	12	7	14	8	20	11	8	5
		F189	163	93	11	6	1	1	0	0	0	0	1	1	5	3	5	3	2	1
		F190	98	56	49	28	19	11	8	5	1	1	33	19	26	15	31	18	17	10
		F191	150	86	23	13	2	1	0	0	0	0	7	4	2	1	12	7	3	2
	53	T094	40	75	13	25	0	0	0	0	0	0	7	13	2	4	4	8	0	0
		T095	22	42	16	30	11	21	2	4	2	4	13	25	15	28	10	19	6	11
		T103	49	92	3	6	1	2	0	0	0	0	2	4	1	2	1	2	1	2
		T105	32	60	11	21	6	11	4	8	0	0	8	15	8	15	12	23	5	9
		T117	34	64	16	30	1	2	2	4	0	0	11	21	4	8	6	11	3	6
		T127	48	91	5	9	0	0	0	0	0	0	1	2	1	2	2	4	1	2
		T129	47	89	5	9	1	2	0	0	0	0	2	4	0	0	2	4	3	6
		T139	44	83	7	13	2	4	0	0	0	0	0	0	4	8	3	6	3	6
		T143	42	79	8	15	3	6	0	0	0	0	3	6	5	9	3	6	1	2
		T144	45	85	8	15	0	0	0	0	0	0	1	2	1	2	3	6	2	4
		T152	52	98	1	2	0	0	0	0	0	0	1	2	0	0	0	0	0	0
		T163	30	57	16	30	5	9	2	4	0	0	3	6	9	17	8	15	6	11
		T164	47	89	4	8	2	4	0	0	0	0	2	4	5	9	1	2	0	0
		T165	50	94	3	6	0	0	0	0	0	0	1	2	0	0	0	0	1	2

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
SOUTH CAROLINA	104	F015	94	90	8	8	1	1	1	1	0	0	3	3	7	7	3	3	0	0
		F062	101	97	3	3	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		F071	102	98	2	2	0	0	0	0	0	0	2	2	0	0	0	0	0	0
		F073	82	79	20	19	2	2	0	0	0	0	9	9	6	6	3	3	3	3
		F101	100	96	4	4	0	0	0	0	0	0	0	0	0	0	3	3	1	1
		F105	86	83	15	14	3	3	0	0	0	0	4	4	5	5	10	10	1	1
		F111	66	63	25	24	10	10	2	2	1	1	6	6	18	17	19	18	10	10
		F112	67	64	21	20	11	11	4	4	1	1	5	5	21	20	18	17	12	12
		F123	91	88	11	11	2	2	0	0	0	0	2	2	10	10	2	2	1	1
		F134	85	82	12	12	4	4	3	3	0	0	5	5	10	10	7	7	7	7
		F135	88	85	11	11	4	4	1	1	0	0	2	2	8	8	5	5	7	7
		F136	62	60	28	27	10	10	3	3	1	1	9	9	18	17	17	16	15	14
		F173	89	86	13	13	2	2	0	0	0	0	4	4	3	3	3	3	7	7
		F175	82	79	21	20	1	1	0	0	0	0	6	6	5	5	3	3	8	8
		F176	79	76	19	18	6	6	0	0	0	0	5	5	6	6	7	7	11	11
		F177	100	96	4	4	0	0	0	0	0	0	1	1	1	1	1	1	0	0
		F178	90	87	12	12	1	1	1	1	0	0	6	6	6	6	2	2	2	2
		F180	93	89	11	11	0	0	0	0	0	0	3	3	2	2	2	2	4	4
		F181	100	96	4	4	0	0	0	0	0	0	0	0	2	2	1	1	1	1
		F182	99	95	5	5	0	0	0	0	0	0	1	1	1	1	1	1	0	0
		F186	54	52	36	35	14	13	0	0	0	0	10	10	24	23	11	11	12	12
		F189	90	87	13	13	1	1	0	0	0	0	0	0	7	7	4	4	3	3
		F190	51	49	38	37	10	10	5	5	0	0	16	15	26	25	12	12	15	14
		F191	100	96	3	3	1	1	0	0	0	0	0	0	2	2	3	3	0	0
		F636			3		0		0		0		2		1		0		0	
		F640			1		0		0		0		0		0		0		0	
		F648			5		0		0		0		3		1		0		0	
		F650			2		0		0		0		1		0		0		0	
	29	T094	26	90	3	10	0	0	0	0	0	0	0	0	1	3	0	0	1	3
		T095	22	76	7	24	0	0	0	0	0	0	1	3	2	7	1	3	1	3
		T103	24	83	5	17	0	0	0	0	0	0	1	3	3	10	1	3	0	0
		T105	20	69	7	24	0	0	2	7	0	0	2	7	1	3	1	3	5	17
		T117	17	59	8	28	4	14	0	0	0	0	4	14	5	17	1	3	1	3
		T127	28	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	1	3
		T129	21	72	5	17	2	7	1	3	0	0	0	0	3	10	4	14	4	14
		T135	28	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	1	3
		T139	21	72	6	21	1	3	1	3	0	0	3	10	3	10	2	7	2	7
		T143	25	86	4	14	0	0	0	0	0	0	0	0	0	0	1	3	1	3
		T144	26	90	2	7	1	3	0	0	0	0	1	3	1	3	0	0	1	3
		T152	26	90	3	10	0	0	0	0	0	0	1	3	1	3	0	0	1	3
		T163	25	86	4	14	0	0	0	0	0	0	1	3	1	3	1	3	0	0
		T164	28	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
TENNESSEE	85	P015	77	91	6	7	2	2	0	0	0	0	2	2	4	5	1	1	3	4
		P062	84	99	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		P070	83	98	2	2	0	0	0	0	0	0	0	0	1	1	1	1	0	0
		P073	55	65	21	25	6	7	2	2	1	1	18	21	19	22	6	7	0	0
		P101	83	98	2	2	0	0	0	0	0	0	1	1	0	0	1	1	0	0
		P105	83	98	2	2	0	0	0	0	0	0	1	1	0	0	1	1	0	0
		P111	70	82	14	16	1	1	0	0	0	0	4	5	4	5	7	8	1	1
		P112	68	80	15	18	1	1	1	1	0	0	7	8	7	8	6	7	0	0
		P123	77	91	6	7	2	2	0	0	0	0	5	6	4	5	1	1	0	0
		P134	75	88	9	11	1	1	0	0	0	0	4	5	4	5	2	2	1	1
		P135	73	86	10	12	2	2	0	0	0	0	5	6	5	6	2	2	2	2
		P136	60	71	9	11	12	14	3	4	1	1	22	26	13	15	7	8	4	5
		P173	75	88	8	9	1	1	1	1	0	0	5	6	3	4	2	2	3	4
		P175	71	84	12	14	1	1	1	1	0	0	5	6	3	4	5	6	3	4
		P176	63	74	18	21	2	2	2	2	0	0	14	16	6	7	4	5	3	4
		P177	71	84	10	12	3	4	1	1	0	0	5	6	8	9	3	4	3	4
		P178	64	75	16	19	4	5	1	1	0	0	5	6	10	12	8	9	4	5
		P180	63	74	16	19	4	5	2	2	0	0	9	11	12	14	6	7	3	4
		P181	80	94	5	6	0	0	0	0	0	0	1	1	3	4	1	1	0	0
		P182	69	81	13	15	3	4	0	0	0	0	2	2	7	8	4	5	6	7
		P186	66	78	16	19	2	2	1	1	0	0	8	9	8	9	6	7	1	1
		P189	80	94	5	6	0	0	0	0	0	0	3	4	2	2	0	0	0	0
		P190	53	62	25	29	7	8	0	0	0	0	25	29	6	7	5	6	3	4
		P191	73	86	11	13	1	1	0	0	0	0	2	2	6	7	2	2	2	2
		P636			1		0		0		0		1		0		0		0	
		P640			1		0		0		0		1		0		0		0	
		P650			3		0		0		0		3		0		0		0	
	165	T094	122	74	30	18	9	5	4	2	0	0	14	8	9	5	18	11	17	10
		T095	125	76	26	16	11	7	3	2	0	0	9	5	16	10	16	10	10	6
		T103	122	74	39	24	3	2	1	1	0	0	23	14	8	5	11	7	4	2
		T105	57	35	66	40	30	18	7	4	5	3	68	41	49	30	25	15	21	13
		T117	35	21	64	39	31	19	26	16	9	5	70	42	69	42	51	31	42	25
		T118	135	82	28	17	2	1	0	0	0	0	14	8	15	9	2	1	1	1
		T127	143	87	18	11	3	2	1	1	0	0	4	2	9	5	7	4	4	2
		T129	121	73	32	19	9	5	3	2	0	0	10	6	18	11	17	10	10	6
		T135	158	96	6	4	1	1	0	0	0	0	1	1	6	4	1	1	0	0
		T139	124	75	37	22	4	2	0	0	0	0	13	8	8	5	11	7	10	6
		T143	125	76	32	19	6	4	2	1	0	0	20	12	15	9	11	7	3	2
		T144	127	77	30	18	6	4	2	1	0	0	12	7	18	11	9	5	6	4
		T152	130	79	24	15	9	5	2	1	0	0	18	11	15	9	6	4	7	4
		T163	46	28	77	47	35	21	7	4	0	0	52	32	51	31	36	22	25	15
		T164	135	82	28	17	2	1	0	0	0	0	12	7	13	8	2	1	4	2
		T165	138	84	19	12	9	5	0	0	0	0	21	13	10	6	1	1	3	2

REGION	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 05	2168	F015	2125	98	42	2	1	0	0	0	0	0	20	1	10	0	3	0	3	0
		F062	2154	99	14	1	0	0	0	0	0	0	4	0	6	0	2	0	1	0
		F070	2115	98	49	2	4	0	0	0	0	0	13	1	22	1	10	0	2	0
		F071	2134	98	33	2	1	0	0	0	0	0	5	0	16	1	9	0	1	0
		F073	1789	83	310	14	58	3	10	0	1	0	110	5	116	5	82	4	64	3
		F101	2153	99	15	1	0	0	0	0	0	0	10	0	2	0	1	0	2	0
		F105	2109	97	54	2	5	0	0	0	0	0	16	1	16	1	11	1	3	0
		F111	1753	81	318	15	76	4	18	1	3	0	104	5	96	4	101	5	89	4
		F112	1676	77	374	17	101	5	15	1	2	0	103	5	139	6	117	5	122	6
		F123	2042	94	121	6	5	0	0	0	0	0	23	1	37	2	23	1	17	1
		F134	1997	92	156	7	13	1	2	0	0	0	25	1	37	2	27	1	25	1
		F135	1888	87	231	11	45	2	4	0	0	0	70	3	68	3	40	2	38	2
		F136	1562	72	396	18	139	6	44	2	27	1	220	10	186	9	139	6	118	5
		F173	2003	92	143	7	21	1	1	0	0	0	45	2	44	2	18	1	19	1
		F175	1876	87	237	11	39	2	16	1	0	0	90	4	95	4	45	2	34	2
		F176	1630	75	408	19	95	4	32	1	3	0	147	7	145	7	115	5	97	4
		F177	2081	96	82	4	5	0	0	0	0	0	23	1	23	1	12	1	7	0
		F178	1884	87	227	10	42	2	14	1	1	0	93	4	63	3	46	2	56	3
		F180	1848	85	262	12	50	2	8	0	0	0	94	4	94	4	71	3	22	1
		F181	2138	99	29	1	1	0	0	0	0	0	5	0	5	0	9	0	4	0
		F182	2042	94	114	5	12	1	0	0	0	0	21	1	44	2	23	1	13	1
		F186	1493	69	468	22	161	7	40	2	6	0	171	8	203	9	164	8	150	7
		F189	2099	97	67	3	2	0	0	0	0	0	17	1	14	1	12	1	10	0
		F190	1407	65	524	24	166	8	60	3	11	1	253	12	223	10	180	8	167	8
		F191	1944	90	202	9	22	1	0	0	0	0	61	3	61	3	43	2	38	2
		F609			7		0		0		0		4		1		1		0	
		F636			79		4		0		0		48		28		8		0	
		F640			83		6		0		0		58		22		8		2	
		F648			73		3		0		0		46		16		10		5	
		F650			63		5		0		0		43		17		12		0	
	2083	T094	1649	79	332	16	84	4	16	1	2	0	54	3	94	5	106	5	137	7
		T095	1583	76	371	18	100	5	23	1	6	0	120	6	136	7	104	5	132	6
		T103	1552	75	412	20	93	4	25	1	1	0	111	5	122	6	125	6	150	7
		T105	1627	78	355	17	84	4	15	1	2	0	117	6	120	6	90	4	99	5
		T117	775	37	482	23	364	17	291	14	171	8	500	24	606	29	500	24	548	26
		T118	1975	95	94	5	14	1	0	0	0	0	7	0	22	1	34	2	18	1
		T127	1881	90	192	9	10	0	0	0	0	0	32	2	42	2	47	2	42	2
		T129	1607	77	400	19	67	3	9	0	0	0	70	3	101	5	125	6	104	5
		T135	2043	98	38	2	2	0	0	0	0	0	6	0	8	0	6	0	11	1
		T139	1155	55	542	26	266	13	90	4	30	1	200	10	307	15	305	15	335	16
		T143	1593	76	383	18	92	4	14	1	1	0	79	4	133	6	126	6	106	5
		T144	1613	77	333	16	92	4	36	2	9	0	79	4	135	6	115	6	124	6
		T152	1875	90	144	7	48	2	13	1	3	0	74	4	84	4	50	2	47	2
		T163	1395	67	460	22	177	8	46	2	5	0	123	6	192	9	227	11	186	9
		T164	1890	91	171	8	15	1	7	0	0	0	53	3	29	1	36	2	43	2
		T165	1876	90	182	9	21	1	4	0	0	0	53	3	44	2	38	2	42	2
		T169	2046	98	35	2	1	0	1	0	0	0	5	0	5	0	2	0	5	0
		T309			2		1		0		0		0		0		0		0	
		T336			3		0		0		0		0		0		1		0	
		T340			11		0		0		0		0		1		3		2	
		T348			12		0		0		0		0		0		2		2	
		T350			8		0		0		0		0		0		3		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
ILLINOIS	466	F015	461	99	5	1	0	0	0	0	0	0	2	0	0	0	1	0	0	0
		F070	463	99	3	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
		F071	462	99	4	1	0	0	0	0	0	0	1	0	1	0	0	0	0	0
		F073	423	91	40	9	2	0	1	0	0	0	14	3	10	2	8	2	4	1
		F105	463	99	3	1	0	0	0	0	0	0	0	0	1	0	2	0	0	0
		F111	417	89	42	9	7	2	0	0	0	0	9	2	9	2	5	1	16	3
		F112	351	75	78	17	29	6	7	2	1	0	22	5	31	7	33	7	41	9
		F123	436	94	30	6	0	0	0	0	0	0	7	2	2	0	5	1	11	2
		F134	426	91	36	8	4	1	0	0	0	0	3	1	7	2	8	2	8	2
		F135	381	82	66	14	18	4	1	0	0	0	17	4	18	4	18	4	13	3
		F136	331	71	97	21	23	5	9	2	6	1	37	8	54	12	35	8	25	5
		F173	447	96	18	4	1	0	0	0	0	0	1	0	2	0	1	0	4	1
		F175	424	91	38	8	2	0	2	0	0	0	5	1	8	2	6	1	5	1
		F176	389	83	68	15	7	2	2	0	0	0	11	2	17	4	10	2	18	4
		F177	460	99	6	1	0	0	0	0	0	0	0	0	2	0	1	0	0	0
		F178	433	93	28	6	4	1	1	0	0	0	7	2	11	2	5	1	6	1
		F180	430	92	33	7	3	1	0	0	0	0	11	2	11	2	3	1	5	1
		F181	461	99	5	1	0	0	0	0	0	0	1	0	0	0	1	0	2	0
		F182	417	89	46	10	3	1	0	0	0	0	6	1	21	5	7	2	6	1
		F186	298	64	108	23	47	10	12	3	1	0	39	8	60	13	59	13	43	9
		F189	458	98	8	2	0	0	0	0	0	0	1	0	1	0	2	0	2	0
		F190	296	64	117	25	42	9	11	2	0	0	52	11	59	13	43	9	41	9
		F191	419	90	39	8	8	2	0	0	0	0	11	2	11	2	11	2	11	2
		F609			4		0		0		0		3		0		0		0	
		F636			12		0		0		0		9		3		0		0	
		F640			33		1		0		0		21		11		1		0	
		F648			10		0		0		0		8		2		0		0	
		F650			8		0		0		0		7		1		0		0	
	405	T094	319	79	72	18	12	3	2	0	0	0	13	3	22	5	19	5	31	8
		T095	305	75	65	16	20	5	11	3	4	1	21	5	42	10	25	6	33	8
		T103	345	85	53	13	6	1	1	0	0	0	11	3	13	3	9	2	19	5
		T105	309	76	73	18	19	5	3	1	1	0	12	3	20	5	17	4	36	9
		T117	31	8	67	17	93	23	127	31	87	21	207	51	225	56	196	48	200	49
		T118	385	95	17	4	3	1	0	0	0	0	0	0	2	0	8	2	5	1
		T127	351	87	49	12	5	1	0	0	0	0	8	2	14	3	18	4	11	3
		T129	350	86	47	12	7	2	1	0	0	0	8	2	12	3	15	4	7	2
		T135	402	99	3	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
		T139	318	79	67	17	19	5	1	0	0	0	9	2	19	5	20	5	34	8
		T143	305	75	77	19	21	5	2	0	0	0	20	5	37	9	29	7	23	6
		T144	294	73	88	22	17	4	6	1	0	0	20	5	44	11	32	8	17	4
		T152	394	97	11	3	0	0	0	0	0	0	1	0	2	0	2	0	3	1
		T163	258	64	103	25	34	8	8	2	2	0	8	2	31	8	57	14	55	14
		T164	374	92	29	7	1	0	1	0	0	0	6	1	5	1	4	1	9	2
		T165	384	95	20	5	0	0	1	0	0	0	6	1	5	1	3	1	5	1
		T169	402	99	3	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		T309			2		0		0		0		0		0		0		0	
		T340			7		0		0		0		0		0		2		1	
		T348			1		0		0		0		0		0		0		0	
		T350			3		0		0		0		0		0		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
INDIANA	197	F015	196	99	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
		F071	196	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F073	127	64	56	28	11	6	3	2	0	0	27	14	18	9	10	5	18	9
		F105	192	97	5	3	0	0	0	0	0	0	0	0	1	1	0	0	0	0
		F111	112	57	50	25	23	12	11	6	1	1	16	8	9	5	15	8	29	15
		F112	130	66	49	25	16	8	2	1	0	0	16	8	2	1	6	3	22	11
		F123	192	97	4	2	1	1	0	0	0	0	0	0	1	1	0	0	0	0
		F134	165	84	29	15	2	1	1	1	0	0	3	2	1	1	2	1	3	2
		F135	151	77	37	19	8	4	1	1	0	0	8	4	2	1	0	0	13	7
		F136	47	24	59	30	46	23	24	12	21	11	61	31	27	14	17	9	57	29
		F173	154	78	30	15	12	6	1	1	0	0	9	5	6	3	3	2	10	5
		F175	132	67	43	22	13	7	9	5	0	0	20	10	11	6	3	2	19	10
		F176	94	48	52	26	30	15	19	10	2	1	14	7	7	4	14	7	38	19
		F177	171	87	24	12	2	1	0	0	0	0	5	3	3	2	1	1	3	2
		F178	99	50	61	31	25	13	11	6	1	1	23	12	13	7	11	6	34	17
		F180	165	84	30	15	2	1	0	0	0	0	15	8	5	3	1	1	1	1
		F181	194	98	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F182	183	93	12	6	2	1	0	0	0	0	3	2	2	1	0	0	0	0
		F186	82	42	56	28	41	21	13	7	5	3	22	11	11	6	17	9	41	21
		F189	193	98	4	2	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F190	63	32	65	33	34	17	27	14	8	4	37	19	24	12	20	10	54	27
		F191	187	95	10	5	0	0	0	0	0	0	0	0	1	1	1	1	3	2
	462	T094	309	67	102	22	38	8	11	2	2	0	13	3	26	6	40	9	58	13
		T095	303	66	122	26	31	7	5	1	1	0	40	9	26	6	21	5	35	8
		T103	252	55	146	32	45	10	19	4	0	0	33	7	40	9	59	13	68	15
		T105	282	61	132	29	38	8	9	2	1	0	51	11	45	10	27	6	36	8
		T117	72	16	105	23	106	23	108	23	71	15	115	25	170	37	141	31	192	42
		T118	397	86	55	12	10	2	0	0	0	0	2	0	11	2	22	5	9	2
		T127	439	95	22	5	1	0	0	0	0	0	1	0	3	1	1	0	5	1
		T129	286	62	135	29	37	8	4	1	0	0	24	5	34	7	38	8	49	11
		T135	444	96	16	3	2	0	0	0	0	0	2	0	2	0	3	1	7	2
		T139	110	24	152	33	127	27	53	11	20	4	71	15	109	24	143	31	155	34
		T143	286	62	130	28	38	8	7	2	1	0	28	6	28	6	31	7	39	8
		T144	276	60	109	24	48	10	21	5	8	2	32	7	43	9	36	8	62	13
		T152	439	95	23	5	0	0	0	0	0	0	14	3	5	1	0	0	1	0
		T163	316	68	108	23	31	7	7	2	0	0	25	5	38	8	39	8	36	8
		T164	365	79	84	18	9	2	4	1	0	0	32	7	16	3	17	4	17	4
		T165	422	91	38	8	2	0	0	0	0	0	16	3	3	1	3	1	6	1
		T169	457	99	4	1	1	0	0	0	0	0	1	0	1	0	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MICHIGAN	300	P015	276	92	24	8	0	0	0	0	0	0	10	3	6	2	2	1	3	1
		P062	294	98	6	2	0	0	0	0	0	0	0	0	2	1	2	1	1	0
		P070	297	99	3	1	0	0	0	0	0	0	0	0	0	0	2	1	0	0
		P071	297	99	2	1	1	0	0	0	0	0	0	0	1	0	1	0	0	0
		P073	232	77	54	18	12	4	2	1	0	0	6	2	30	10	28	9	1	0
		P101	288	96	12	4	0	0	0	0	0	0	9	3	2	1	9	0	1	0
		P105	260	87	35	12	5	2	0	0	0	0	13	4	10	3	7	2	3	1
		P111	204	68	71	24	23	8	2	1	0	0	30	10	33	11	30	10	4	1
		P112	183	61	88	29	26	9	3	1	0	0	17	6	49	16	35	12	5	2
		P123	270	90	27	9	3	1	0	0	0	0	5	2	11	4	6	2	3	1
		P134	259	86	38	13	3	1	0	0	0	0	5	2	8	3	6	2	4	1
		P135	238	79	47	16	14	5	1	0	0	0	10	3	23	8	12	4	4	1
		P136	170	57	91	30	34	11	5	2	0	0	33	11	59	20	52	17	4	1
		P173	261	87	36	12	3	1	0	0	0	0	9	3	16	5	2	1	2	1
		P175	229	76	57	19	10	3	4	1	0	0	23	8	35	12	11	4	2	1
		P176	145	48	110	37	36	12	8	3	1	0	49	16	69	23	42	14	4	1
		P177	279	93	19	6	2	1	0	0	0	0	7	2	6	2	4	1	1	0
		P178	257	86	35	12	8	3	0	0	0	0	12	4	11	4	15	5	1	0
		P180	164	55	97	32	34	11	5	2	0	0	28	9	45	15	37	12	4	1
		P181	285	95	14	5	1	0	0	0	0	0	3	1	3	1	4	1	2	1
		P182	278	93	17	6	5	2	0	0	0	0	0	0	8	3	9	3	1	0
		P186	177	59	86	29	26	9	11	4	0	0	34	11	50	17	28	9	7	2
		P189	278	93	22	7	0	0	0	0	0	0	4	1	5	2	3	1	3	1
		P190	173	58	79	26	36	12	11	4	1	0	39	13	51	17	36	12	3	1
		P191	263	88	34	11	3	1	0	0	0	0	9	3	11	4	8	3	0	0
		P609	299		1		0		0		0		1		0		0		0	
		P636	282		18		0		0		0		13		2		1		0	
		P640	284		15		1		0		0		11		2		2		0	
		P648	293		7		0		0		0		1		3		3		0	
		P650	275		22		3		0		0		14		10		4		0	
	174	T094	149	86	18	10	7	4	0	0	0	0	4	2	6	3	0	0	0	0
		T095	153	88	18	10	3	2	0	0	0	0	3	2	5	3	3	2	0	0
		T103	142	82	29	17	3	2	0	0	0	0	5	3	7	4	1	1	1	1
		T105	141	81	25	14	7	4	1	1	0	0	10	6	13	7	4	2	2	1
		T117	133	76	31	18	9	5	1	1	0	0	7	4	10	6	2	1	0	0
		T118	173	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		T127	159	91	15	9	0	0	0	0	0	0	2	1	3	2	0	0	0	0
		T129	143	82	29	17	2	1	0	0	0	0	7	4	0	0	1	1	0	0
		T135	171	98	3	2	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		T139	111	64	48	28	14	8	1	1	0	0	4	2	13	7	3	2	1	1
		T143	143	82	29	17	2	1	0	0	0	0	9	5	10	6	2	1	0	0
		T144	145	83	24	14	4	2	1	1	0	0	7	4	7	4	2	1	0	0
		T152	168	97	6	3	0	0	0	0	0	0	0	0	2	1	0	0	0	0
		T163	119	68	42	24	13	7	0	0	0	0	7	4	15	9	6	3	1	1
		T164	169	97	4	2	1	1	0	0	0	0	1	1	1	1	0	0	0	0
		T165	167	96	4	2	3	2	0	0	0	0	0	0	0	0	0	0	1	1
		T169	171	98	2	1	0	0	1	1	0	0	1	1	0	0	0	0	0	0
		T340	173		1		0		0		0		0		0		0		1	
		T348	173		1		0		0		0		0		0		0		0	
		T350	173		1		0		0		0		0		0		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MINNESOTA	371	P062	369	99	2	1	0	0	0	0	0	0	0	0	2	1	0	0	0	0
		P070	340	92	29	8	2	1	0	0	0	0	12	3	16	4	5	1	0	0
		P071	368	99	3	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0
		P073	366	99	5	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0
		P105	370	100	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		P111	307	83	54	15	7	2	2	1	1	0	10	3	10	3	18	5	20	5
		P112	322	87	42	11	7	2	0	0	0	0	5	1	6	2	16	4	18	5
		P123	359	97	12	3	0	0	0	0	0	0	1	0	3	1	2	1	0	0
		P134	368	99	3	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0
		P135	360	97	10	3	1	0	0	0	0	0	5	1	0	0	1	0	2	1
		P136	300	81	54	15	15	4	2	1	0	0	25	7	15	4	10	3	14	4
		P173	369	99	2	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
		P175	346	93	22	6	3	1	0	0	0	0	13	4	5	1	5	1	3	1
		P176	339	91	31	8	1	0	0	0	0	0	13	4	2	1	3	1	7	2
		P177	370	100	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		P178	356	96	15	4	0	0	0	0	0	0	9	2	4	1	1	0	1	0
		P180	364	98	6	2	1	0	0	0	0	0	1	0	1	0	0	0	1	0
		P181	370	100	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
		P182	363	98	8	2	0	0	0	0	0	0	2	1	3	1	1	0	2	1
		P186	316	85	44	12	9	2	2	1	0	0	13	4	14	4	20	5	7	2
		P189	368	99	3	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0
		P190	277	75	74	20	17	5	3	1	0	0	28	8	19	5	30	8	21	6
		P191	337	91	31	8	3	1	0	0	0	0	10	3	7	2	9	2	7	2
		P636			3		0		0		0		3		0		0		0	
		P640			1		0		0		0		1		0		0		0	
	365	T094	317	87	44	12	4	1	0	0	0	0	4	1	11	3	12	3	11	3
		T095	302	83	52	14	10	3	0	0	1	0	12	3	13	4	14	4	15	4
		T103	344	94	19	5	2	1	0	0	0	0	4	1	5	1	5	1	8	2
		T105	360	99	4	1	1	0	0	0	0	0	1	0	2	1	1	0	1	0
		T117	215	59	96	26	45	12	8	2	1	0	31	8	51	14	49	13	51	14
		T118	364	100	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
		T127	333	91	32	9	0	0	0	0	0	0	7	2	8	2	7	2	5	1
		T129	299	82	61	17	5	1	0	0	0	0	11	3	18	5	24	7	10	3
		T135	364	100	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T139	269	74	75	21	20	5	1	0	0	0	19	5	36	10	29	8	25	7
		T143	321	88	37	10	5	1	2	1	0	0	2	1	19	5	14	4	9	2
		T144	325	89	27	7	8	2	4	1	1	0	6	2	14	4	17	5	12	3
		T152	314	86	30	8	13	4	6	2	2	1	11	3	26	7	21	6	19	5
		T163	353	97	12	3	0	0	0	0	0	0	2	1	1	0	4	1	3	1
		T164	348	95	15	4	2	1	0	0	0	0	7	2	1	0	2	1	7	2
		T165	360	99	5	1	0	0	0	0	0	0	0	0	1	0	1	0	1	0
		T169	354	97	11	3	0	0	0	0	0	0	0	0	0	0	2	1	4	1
		T336			1		0		0		0		0		0		1		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
OHIO	449	F015	442	121	7	2	0	0	0	0	0	0	5	1	0	0	0	0	0	0
		F062	448	123	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
		F070	448	123	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		F071	445	122	4	1	0	0	0	0	0	0	2	1	2	1	0	0	0	0
		F073	319	87	100	27	27	7	2	1	1	0	37	10	31	8	29	8	35	10
		F101	448	123	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
		F105	445	122	4	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0
		F111	390	107	48	13	9	2	1	0	1	0	22	6	9	2	16	4	14	4
		F112	360	99	69	19	16	4	3	1	1	0	26	7	25	7	21	6	28	8
		F123	424	116	25	7	0	0	0	0	0	0	6	2	11	3	2	1	1	0
		F134	409	112	36	10	4	1	0	0	0	0	11	3	14	4	5	1	9	2
		F135	410	112	36	10	3	1	0	0	0	0	14	4	11	3	5	1	5	1
		F136	355	97	69	19	21	6	4	1	0	0	50	14	26	7	24	7	16	4
		F173	404	111	42	12	3	1	0	0	0	0	24	7	13	4	5	1	1	0
		F175	385	105	57	16	7	2	0	0	0	0	26	7	19	5	13	4	3	1
		F176	358	98	82	22	8	2	1	0	0	0	38	10	24	7	19	5	10	3
		F177	423	116	26	7	0	0	0	0	0	0	10	3	8	2	3	1	3	1
		F178	381	104	63	17	3	1	2	1	0	0	32	9	15	4	9	2	10	3
		F180	365	100	72	20	10	3	2	1	0	0	35	10	21	6	23	6	9	2
		F181	447	122	2	1	0	0	0	0	0	0	1	0	1	0	0	0	0	0
		F182	433	119	14	4	2	1	0	0	0	0	7	2	2	1	3	1	3	1
		F186	334	92	87	24	26	7	2	1	0	0	33	9	30	8	22	6	38	10
		F189	436	119	12	3	1	0	0	0	0	0	1	0	2	1	3	1	4	1
		F190	327	90	94	26	21	6	5	1	2	1	47	13	31	8	26	7	35	10
		F191	421	115	27	7	1	0	0	0	0	0	7	2	5	1	4	1	8	2
		F609			2		0		0		0		0		1		1		0	
		F636			13		0		0		0		6		4		2		0	
		F640			31		3		0		0		24		5		5		2	
		F648			49		3		0		0		37		7		5		4	
		F650			29		2		0		0		22		3		7		0	
	603	T094	499	83	82	14	20	3	2	0	0	0	18	3	26	4	29	5	30	5
		T095	453	75	109	18	34	6	7	1	0	0	40	7	49	8	40	7	48	8
		T103	400	66	160	27	37	6	5	1	1	0	56	9	56	9	51	8	53	9
		T105	462	77	120	20	19	3	2	0	0	0	42	7	40	7	41	7	24	4
		T117	266	44	169	28	110	18	46	8	12	2	129	21	144	24	110	18	105	17
		T118	582	97	20	3	1	0	0	0	0	0	3	0	9	1	4	1	4	1
		T127	539	89	60	10	4	1	0	0	0	0	10	2	10	2	19	3	18	3
		T129	461	76	122	20	16	3	4	1	0	0	17	3	36	6	47	8	37	6
		T135	588	98	15	2	0	0	0	0	0	0	3	0	6	1	3	0	3	0
		T139	281	47	194	32	84	14	34	6	10	2	95	16	127	21	108	18	119	20
		T143	466	77	108	18	26	4	3	0	0	0	20	3	39	6	48	8	35	6
		T144	502	83	82	14	15	2	4	1	0	0	12	2	27	4	27	4	33	5
		T152	489	81	71	12	35	6	7	1	1	0	47	8	48	8	27	4	24	4
		T163	284	47	188	31	98	16	30	5	3	0	79	13	105	17	119	20	90	15
		T164	563	93	36	6	2	0	2	0	0	0	7	1	6	1	13	2	10	2
		T165	470	78	114	19	16	3	3	0	0	0	31	5	35	6	31	5	29	5
		T169	593	98	10	2	0	0	0	0	0	0	3	0	3	0	0	0	1	0
		T336			1		0		0		0		0		0		0		0	
		T340			3		0		0		0		0		1		1		0	
		T348			10		0		0		0		0		0		2		2	
		T350			4		0		0		0		0		0		3		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
WISCONSIN	385	F015	379	98	5	1	1	0	0	0	0	0	3	1	3	1	0	0	0	0
		F062	380	99	5	1	0	0	0	0	0	0	3	1	2	1	0	0	0	0
		F070	370	96	13	3	2	1	0	0	0	0	1	0	5	1	3	1	1	0
		F071	366	95	19	5	0	0	0	0	0	0	1	0	11	3	7	2	0	0
		F073	322	84	55	14	6	2	2	1	0	0	25	6	26	7	6	2	6	2
		F101	383	99	2	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0
		F105	379	98	6	2	0	0	0	0	0	0	2	1	3	1	1	0	0	0
		F111	323	84	53	14	7	2	2	1	0	0	17	4	26	7	17	4	6	2
		F112	330	86	48	12	7	2	0	0	0	0	17	4	26	7	6	2	8	2
		F123	361	94	23	6	1	0	0	0	0	0	4	1	9	2	8	2	2	1
		F134	370	96	14	4	0	0	1	0	0	0	2	1	7	2	5	1	1	0
		F135	348	90	35	9	1	0	1	0	0	0	16	4	14	4	4	1	1	0
		F136	359	93	26	7	0	0	0	0	0	0	14	4	5	1	1	0	2	1
		F173	368	96	15	4	2	1	0	0	0	0	1	0	7	2	7	2	2	1
		F175	360	94	20	5	4	1	1	0	0	0	3	1	17	4	7	2	2	1
		F176	305	79	65	17	13	3	2	1	0	0	22	6	26	7	27	7	20	5
		F177	378	98	6	2	1	0	0	0	0	0	1	0	4	1	3	1	0	0
		F178	358	93	25	6	2	1	0	0	0	0	10	3	9	2	5	1	4	1
		F180	360	94	24	6	0	0	1	0	0	0	4	1	11	3	7	2	2	1
		F181	381	99	4	1	0	0	0	0	0	0	0	0	1	0	3	1	0	0
		F182	368	96	17	4	0	0	0	0	0	0	3	1	8	2	3	1	1	0
		F186	286	74	87	23	12	3	0	0	0	0	30	8	38	10	18	5	14	4
		F189	366	95	18	5	1	0	0	0	0	0	10	3	6	2	3	1	0	0
		F190	271	70	95	25	16	4	3	1	0	0	50	13	39	10	25	6	13	3
		F191	317	82	61	16	7	2	0	0	0	0	24	6	26	7	10	3	9	2
		F636			33		4		0		0		17		19		5		0	
		F640			3		1		0		0		1		4		0		0	
		F648			7		0		0		0		0		4		2		1	
		F650			4		0		0		0		0		3		1		0	
	74	T094	56	76	14	19	3	4	1	1	0	0	2	3	3	4	6	8	7	9
		T095	67	91	5	7	2	3	0	0	0	0	4	5	1	1	1	1	1	1
		T103	69	93	5	7	0	0	0	0	0	0	2	3	1	1	0	0	1	1
		T105	73	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		T117	58	78	14	19	1	1	1	1	0	0	11	15	6	8	2	3	0	0
		T127	60	81	14	19	0	0	0	0	0	0	4	5	4	5	2	3	3	4
		T129	68	92	6	8	0	0	0	0	0	0	3	4	1	1	0	0	1	1
		T139	66	89	6	8	2	3	0	0	0	0	2	3	3	4	2	3	1	1
		T143	72	97	2	3	0	0	0	0	0	0	0	0	0	0	2	3	0	0
		T144	71	96	3	4	0	0	0	0	0	0	2	3	0	0	1	1	0	0
		T152	71	96	3	4	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		T163	65	88	7	9	1	1	1	1	0	0	2	3	2	3	2	3	1	1
		T164	71	96	3	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T165	73	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T169	69	93	5	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T309			0		1		0		0		0		0		0		0	
		T336			1		0		0		0		0		0		0		0	

REGION	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 06	429	F015	411	96	18	4	0	0	0	0	0	0	3	1	5	1	4	1	4	1
		F062	418	97	11	3	0	0	0	0	0	0	0	0	1	0	5	1	3	1
		F070	418	97	11	3	0	0	0	0	0	0	3	1	2	0	2	0	4	1
		F071	420	98	9	2	0	0	0	0	0	0	2	0	1	0	3	1	3	1
		F073	402	94	26	6	1	0	0	0	0	0	5	1	7	2	7	2	2	0
		F101	424	99	5	1	0	0	0	0	0	0	0	0	1	0	2	0	2	0
		F105	412	96	14	3	3	1	0	0	0	0	1	0	4	1	5	1	7	2
		F111	364	85	46	11	16	4	3	1	0	0	13	3	22	5	25	6	16	4
		F112	335	78	60	14	24	6	8	2	2	0	27	6	41	10	27	6	25	6
		F123	354	83	64	15	10	2	1	0	0	0	17	4	18	4	18	4	21	5
		F134	331	77	75	17	19	4	4	1	0	0	16	4	30	7	28	7	24	6
		F135	276	64	118	28	28	7	7	2	0	0	26	6	45	10	41	10	42	10
		F136	185	43	101	24	79	18	49	11	15	3	89	21	116	27	103	24	92	21
		F173	391	91	34	8	4	1	0	0	0	0	4	1	13	3	8	2	9	2
		F175	340	79	73	17	12	3	3	1	1	0	27	6	31	7	27	6	15	3
		F176	317	74	84	20	25	6	2	0	1	0	23	5	37	9	39	9	25	6
		F177	378	88	44	10	7	2	0	0	0	0	5	1	19	4	9	2	13	3
		F178	323	75	78	18	22	5	5	1	1	0	22	5	44	10	27	6	27	6
		F180	309	72	73	17	37	9	9	2	1	0	34	8	46	11	34	8	34	8
		F181	403	94	22	5	4	1	0	0	0	0	6	1	3	1	8	2	7	2
		F182	388	90	37	9	4	1	0	0	0	0	6	1	8	2	11	3	13	3
		F186	247	58	108	25	45	10	20	5	9	2	48	11	75	17	82	19	50	12
		F189	395	92	29	7	4	1	1	0	0	0	6	1	5	1	13	3	8	2
		F190	223	52	115	27	54	13	28	7	9	2	68	16	85	20	79	18	71	17
		F191	394	92	30	7	4	1	1	0	0	0	6	1	9	2	13	3	8	2
		F609			3		0		0		0		2		1		0		0	
		F636			7		0		0		0		6		1		0		0	
		F640			19		1		0		0		15		4		2		0	
		F648			5		0		0		0		3		2		0		0	
		F650			26		0		0		0		17		8		1		0	
	1537	T094	1242	81	237	15	42	3	15	1	1	0	49	3	97	6	95	6	66	4
		T095	638	42	455	30	250	16	144	9	50	3	278	18	411	27	362	24	286	19
		T103	1258	82	240	16	27	2	11	1	1	0	63	4	94	6	74	5	54	4
		T105	798	52	443	29	204	13	70	5	22	1	261	17	275	18	272	18	232	15
		T117	377	25	402	26	364	24	286	19	108	7	511	33	636	41	536	35	427	28
		T118	1423	93	107	7	7	0	0	0	0	0	30	2	23	1	22	1	26	2
		T127	1214	79	248	16	63	4	11	1	1	0	41	3	106	7	108	7	74	5
		T129	1074	70	320	21	108	7	31	2	4	0	111	7	180	12	150	10	106	7
		T135	1378	90	107	7	40	3	10	1	2	0	35	2	40	3	57	4	42	3
		T139	1162	76	277	18	69	4	24	2	5	0	129	8	153	10	83	5	73	5
		T143	650	42	503	33	263	17	100	7	21	1	230	15	373	24	313	20	284	18
		T144	824	54	460	30	189	12	56	4	8	1	156	10	269	18	257	17	194	13
		T152	1132	74	281	18	81	5	29	2	14	1	113	7	142	9	165	11	100	7
		T163	990	64	390	25	123	8	27	2	7	0	117	8	177	12	206	13	138	9
		T164	1313	85	189	12	31	2	4	0	0	0	64	4	90	6	43	3	24	2
		T165	1488	97	47	3	1	0	1	0	0	0	9	1	11	1	14	1	10	1
		T169	1504	98	28	2	4	0	0	0	1	0	10	1	10	1	9	1	4	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
ARKANSAS	132	P015	122	92	10	8	0	0	0	0	0	0	1	1	5	4	1	1	3	2
		P062	126	95	6	5	0	0	0	0	0	0	0	0	1	1	1	1	3	2
		P070	126	95	6	5	0	0	0	0	0	0	2	2	1	1	0	0	3	2
		P071	126	95	6	5	0	0	0	0	0	0	2	2	1	1	1	1	2	2
		P073	120	91	11	8	1	1	0	0	0	0	4	3	5	4	2	2	2	2
		P101	127	96	5	4	0	0	0	0	0	0	0	0	1	1	2	2	2	2
		P105	119	90	11	8	2	2	0	0	0	0	1	1	3	2	3	2	7	5
		P111	92	70	26	20	12	9	2	2	0	0	9	7	17	13	13	10	9	7
		P112	70	53	35	27	17	13	8	6	2	2	16	12	35	27	18	14	18	14
		P123	93	70	32	24	7	5	0	0	0	0	6	5	11	8	12	9	13	10
		P134	83	63	35	27	13	10	1	1	0	0	9	7	16	12	14	11	13	10
		P135	66	50	51	39	13	10	2	2	0	0	15	11	19	14	15	11	19	14
		P136	18	14	25	19	38	29	37	28	14	11	65	49	73	55	56	42	45	34
		P173	115	87	15	11	2	2	0	0	0	0	0	0	7	5	5	4	4	3
		P175	74	56	46	35	9	7	2	2	1	1	21	16	23	17	19	14	7	5
		P176	71	54	44	33	15	11	1	1	1	1	14	11	24	18	25	19	9	7
		P177	111	84	19	14	2	2	0	0	0	0	0	0	7	5	3	2	5	4
		P178	78	59	39	30	11	8	3	2	1	1	11	8	24	18	13	10	15	11
		P180	63	48	37	28	23	17	8	6	1	1	20	15	31	23	20	15	21	16
		P181	119	90	10	8	3	2	0	0	0	0	2	2	3	2	5	4	3	2
		P182	114	86	17	13	1	1	0	0	0	0	0	0	4	3	6	5	7	5
		P186	33	25	44	33	29	22	18	14	8	6	28	21	46	35	63	48	32	24
		P189	119	90	11	8	2	2	0	0	0	0	2	2	1	1	5	4	5	4
		P190	27	20	45	34	29	22	22	17	9	7	50	38	50	38	46	35	46	35
		P191	117	89	14	11	1	1	0	0	0	0	2	2	5	4	3	2	5	4
		P609			1		0		0		0		1		0		0		0	
		P636			5		0		0		0		4		1		0		0	
		P640			10		0		0		0		8		2		0		0	
		P648			2		0		0		0		2		0		0		0	
		P650			11		0		0		0		9		1		1		0	
	100	T094	47	47	38	38	9	9	6	6	0	0	6	6	16	16	26	26	17	17
		T095	0	0	9	9	25	25	34	34	32	32	55	55	60	60	70	70	57	57
		T103	75	75	23	23	2	2	0	0	0	0	3	3	10	10	6	6	4	4
		T105	13	13	43	43	24	24	13	13	7	7	38	38	38	38	45	45	25	25
		T117	9	9	20	20	28	28	25	25	18	18	40	40	36	36	66	66	48	48
		T118	92	92	7	7	1	1	0	0	0	0	1	1	5	5	1	1	2	2
		T127	87	87	11	11	2	2	0	0	0	0	1	1	8	8	1	1	4	4
		T129	28	28	44	44	25	25	3	3	0	0	16	16	21	21	48	48	10	10
		T135	81	81	16	16	3	3	0	0	0	0	1	1	1	1	3	3	8	8
		T139	76	76	21	21	3	3	0	0	0	0	3	3	8	8	5	5	6	6
		T143	21	21	39	39	24	24	12	12	4	4	25	25	36	36	37	37	21	21
		T144	19	19	34	34	30	30	15	15	2	2	11	11	33	33	60	60	25	25
		T152	70	70	21	21	6	6	3	3	0	0	8	8	4	4	16	16	6	6
		T163	51	51	33	33	15	15	1	1	0	0	14	14	12	12	18	18	14	14
		T164	90	90	7	7	0	0	3	3	0	0	1	1	2	2	5	5	3	3
		T165	89	89	9	9	1	1	1	1	0	0	1	1	3	3	6	6	1	1
		T169	95	95	4	4	0	0	0	0	1	1	2	2	2	2	2	2	1	1

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
LOUISIANA	32	F062	31	97	1	3	0	0	0	0	0	0	0	0	0	0	1	3	0	0
		F070	31	97	1	3	0	0	0	0	0	0	0	0	0	0	1	3	0	0
		F073	31	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F105	30	94	2	6	0	0	0	0	0	0	0	0	0	0	1	3	0	0
		F111	31	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F112	29	91	2	6	1	3	0	0	0	0	1	3	1	3	0	0	1	3
		F123	30	94	1	3	1	3	0	0	0	0	0	0	1	3	1	3	0	0
		F134	31	97	0	0	0	0	1	3	0	0	0	0	0	0	1	3	0	0
		F135	31	97	0	0	0	0	1	3	0	0	0	0	0	0	1	3	0	0
		F136	23	72	4	13	2	6	3	9	0	0	2	6	4	13	5	16	2	6
		F173	31	97	1	3	0	0	0	0	0	0	0	0	0	0	1	3	0	0
		F175	31	97	1	3	0	0	0	0	0	0	0	0	0	0	1	3	0	0
		F176	30	94	2	6	0	0	0	0	0	0	0	0	0	0	2	6	0	0
		F177	29	91	3	9	0	0	0	0	0	0	1	3	1	3	1	3	0	0
		F178	27	84	5	16	0	0	0	0	0	0	2	6	1	3	1	3	0	0
		F180	29	91	3	9	0	0	0	0	0	0	1	3	1	3	1	3	0	0
		F181	30	94	2	6	0	0	0	0	0	0	0	0	0	0	1	3	0	0
		F182	30	94	2	6	0	0	0	0	0	0	1	3	1	3	0	0	0	0
		F186	20	63	8	25	3	9	0	0	1	3	2	6	7	22	5	16	0	0
		F189	28	88	4	13	0	0	0	0	0	0	0	0	0	0	2	6	0	0
		F190	22	69	6	19	3	9	1	3	0	0	1	3	4	13	4	13	1	3
		F191	24	75	6	19	2	6	0	0	0	0	2	6	2	6	3	9	1	3
		F640			2		1		0		0		0		2		2		0	
		F650			1		0		0		0		0		1		0		0	
	246	T094	186	76	50	20	7	3	2	1	1	0	7	3	17	7	16	7	12	5
		T095	67	27	80	33	56	23	37	15	6	2	74	30	106	43	40	16	28	11
		T103	203	83	36	15	5	2	2	1	0	0	10	4	15	6	7	3	9	4
		T105	183	74	60	24	2	1	1	0	0	0	36	15	12	5	5	2	6	2
		T117	24	10	56	23	73	30	69	28	24	10	152	62	151	61	73	30	36	15
		T118	192	78	50	20	4	2	0	0	0	0	19	8	9	4	9	4	6	2
		T127	168	68	63	26	13	5	1	0	1	0	14	6	17	7	19	8	13	5
		T129	82	33	81	33	55	22	24	10	4	2	53	22	105	43	38	15	29	12
		T135	208	85	30	12	8	3	0	0	0	0	4	2	10	4	6	2	2	1
		T139	135	55	69	28	30	12	10	4	2	1	45	18	50	20	21	9	19	8
		T143	92	37	74	30	50	20	26	11	4	2	37	15	75	30	43	17	29	12
		T144	91	37	86	35	48	20	18	7	3	1	36	15	64	26	38	15	25	10
		T152	196	80	44	18	4	2	2	1	0	0	11	4	12	5	8	3	6	2
		T163	172	70	64	26	8	3	2	1	0	0	10	4	31	13	21	9	12	5
		T164	174	71	58	24	13	5	1	0	0	0	19	8	29	12	11	4	3	1
		T165	237	96	9	4	0	0	0	0	0	0	3	1	3	1	0	0	2	1
		T169	243	99	3	1	0	0	0	0	0	0	0	0	3	1	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NEW MEXICO	14	P015	12	86	2	14	0	0	0	0	0	0	0	0	0	0	1	7	0	0
		P071	13	93	1	7	0	0	0	0	0	0	0	0	0	0	1	7	0	0
		P073	10	71	4	29	0	0	0	0	0	0	0	0	0	0	3	21	0	0
		P105	13	93	1	7	0	0	0	0	0	0	0	0	1	7	0	0	0	0
		P111	12	86	1	7	1	7	0	0	0	0	0	0	0	0	1	7	2	14
		P135	11	79	2	14	1	7	0	0	0	0	2	14	0	0	0	0	2	14
		P136	6	43	2	14	6	43	0	0	0	0	3	21	4	29	5	36	1	7
		P173	12	86	1	7	1	7	0	0	0	0	1	7	0	0	0	0	1	7
		P175	12	86	1	7	1	7	0	0	0	0	1	7	0	0	0	0	1	7
		P176	10	71	2	14	2	14	0	0	0	0	3	21	0	0	1	7	1	7
		P177	12	86	2	14	0	0	0	0	0	0	0	0	0	0	0	0	1	7
		P178	11	79	2	14	0	0	1	7	0	0	0	0	1	7	1	7	1	7
		P180	11	79	1	7	2	14	0	0	0	0	0	0	1	7	1	7	2	14
		P182	13	93	1	7	0	0	0	0	0	0	1	7	0	0	0	0	0	0
		P186	12	86	1	7	1	7	0	0	0	0	2	14	1	7	0	0	0	0
		P189	13	93	1	7	0	0	0	0	0	0	0	0	1	7	0	0	0	0
		P190	9	64	4	29	1	7	0	0	0	0	2	14	2	14	2	14	0	0
		P191	13	93	1	7	0	0	0	0	0	0	0	0	1	7	0	0	0	0
		P640			1		0		0		0		1		0		0		0	
		P648			2		0		0		0		0		2		0		0	
		P650			1		0		0		0		1		0		0		0	
	48	T094	31	65	12	25	5	10	0	0	0	0	2	4	7	15	6	13	3	6
		T095	20	42	7	15	11	23	8	17	2	4	7	15	14	29	19	40	15	31
		T103	20	42	19	40	3	6	5	10	1	2	4	8	13	27	11	23	5	10
		T105	11	23	13	27	14	29	5	10	5	10	20	42	26	54	17	35	10	21
		T117	10	21	5	10	14	29	14	29	5	10	15	31	26	54	20	42	18	38
		T127	34	71	11	23	3	6	0	0	0	0	4	8	8	17	3	6	1	2
		T129	25	52	12	25	9	19	2	4	0	0	7	15	6	13	10	21	7	15
		T135	38	79	8	17	2	4	0	0	0	0	1	2	3	6	3	6	3	6
		T139	14	29	17	35	5	10	9	19	3	6	14	29	24	50	14	29	8	17
		T143	13	27	15	31	16	33	4	8	0	0	12	25	17	35	13	27	10	21
		T144	23	48	15	31	9	19	1	2	0	0	8	17	15	31	5	10	6	13
		T152	43	90	5	10	0	0	0	0	0	0	1	2	1	2	1	2	2	4
		T163	28	58	12	25	6	13	1	2	1	2	7	15	6	13	9	19	5	10
		T165	45	94	3	6	0	0	0	0	0	0	0	0	1	2	1	2	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
OKLAHOMA	12	F062	11	92	1	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F073	11	92	1	8	0	0	0	0	0	0	1	8	0	0	0	0	0	0
		F111	10	83	2	17	0	0	0	0	0	0	1	8	1	8	0	0	0	0
		F112	11	92	1	8	0	0	0	0	0	0	1	8	0	0	0	0	0	0
		F123	9	75	3	25	0	0	0	0	0	0	1	8	0	0	1	8	0	0
		F134	11	92	1	8	0	0	0	0	0	0	1	8	0	0	0	0	0	0
		F135	10	83	2	17	0	0	0	0	0	0	1	8	0	0	1	8	0	0
		F136	10	83	1	8	1	8	0	0	0	0	0	0	2	17	0	0	0	0
		F181	10	83	2	17	0	0	0	0	0	0	1	8	0	0	0	0	0	0
		F182	10	83	2	17	0	0	0	0	0	0	1	8	0	0	1	8	0	0
		F186	6	50	6	50	0	0	0	0	0	0	3	25	3	25	0	0	0	0
		F189	11	92	1	8	0	0	0	0	0	0	1	8	0	0	0	0	0	0
		F190	6	50	4	33	2	17	0	0	0	0	3	25	4	33	0	0	0	0
		F191	10	83	1	8	1	8	0	0	0	0	1	8	1	8	0	0	0	0
		F609			1		0		0		0		1		0		0		0	
		F640			2		0		0		0		2		0		0		0	
		F650			1		0		0		0		1		0		0		0	
	356	T094	329	92	26	7	1	0	0	0	0	0	2	1	8	2	2	1	7	2
		T095	156	44	122	34	56	16	20	6	2	1	46	13	85	24	57	16	63	18
		T103	314	88	38	11	4	1	0	0	0	0	17	5	11	3	9	3	3	1
		T105	221	62	95	27	36	10	3	1	1	0	49	14	37	10	32	9	47	13
		T117	32	9	87	24	90	25	98	28	49	14	124	35	201	56	184	52	149	42
		T118	347	97	9	3	0	0	0	0	0	0	2	1	1	0	3	1	3	1
		T127	181	51	122	34	43	12	10	3	0	0	20	6	60	17	65	18	50	14
		T129	253	71	88	25	13	4	2	1	0	0	19	5	30	8	21	6	34	10
		T135	348	98	8	2	0	0	0	0	0	0	0	0	4	1	2	1	2	1
		T139	240	67	92	26	21	6	3	1	0	0	28	8	38	11	26	7	29	8
		T143	173	49	130	37	45	13	7	2	1	0	28	8	65	18	52	15	67	19
		T144	275	77	69	19	11	3	1	0	0	0	14	4	22	6	21	6	26	7
		T152	202	57	112	31	32	9	9	3	1	0	24	7	43	12	70	20	50	14
		T163	125	35	140	39	68	19	17	5	6	2	51	14	86	24	95	27	56	16
		T164	274	77	71	20	11	3	0	0	0	0	22	6	45	13	13	4	7	2
		T165	338	95	18	5	0	0	0	0	0	0	5	1	2	1	6	2	2	1
		T169	352	99	4	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
TEXAS	239	P015	233	97	6	3	0	0	0	0	0	0	2	1	0	0	2	1	1	0
		P062	236	99	3	1	0	0	0	0	0	0	0	0	0	0	3	1	0	0
		P070	235	98	4	2	0	0	0	0	0	0	1	0	1	0	1	0	1	0
		P071	237	99	2	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0
		P073	230	96	9	4	0	0	0	0	0	0	0	0	2	1	2	1	0	0
		P105	238	100	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
		P111	219	92	16	7	3	1	1	0	0	0	3	1	4	2	11	5	5	2
		P112	211	88	22	9	6	3	0	0	0	0	9	4	5	2	9	4	6	3
		P123	208	87	28	12	2	1	1	0	0	0	10	4	6	3	4	2	8	3
		P134	192	80	39	16	6	3	2	1	0	0	6	3	14	6	13	5	11	5
		P135	158	66	63	26	14	6	4	2	0	0	8	3	26	11	24	10	21	9
		P136	128	54	69	29	32	13	9	4	1	0	19	8	33	14	37	15	44	18
		P173	221	92	17	7	1	0	0	0	0	0	3	1	6	3	2	1	4	2
		P175	211	88	25	10	2	1	1	0	0	0	5	2	8	3	7	3	7	3
		P176	194	81	36	15	8	3	1	0	0	0	6	3	13	5	11	5	15	6
		P177	214	90	20	8	5	2	0	0	0	0	4	2	11	5	5	2	7	3
		P178	195	82	32	13	11	5	1	0	0	0	9	4	18	8	12	5	11	5
		P180	194	81	32	13	12	5	1	0	0	0	13	5	13	5	12	5	11	5
		P181	230	96	8	3	1	0	0	0	0	0	3	1	0	0	2	1	4	2
		P182	221	92	15	6	3	1	0	0	0	0	3	1	3	1	4	2	6	3
		P186	176	74	49	21	12	5	2	1	0	0	13	5	18	8	14	6	18	8
		P189	224	94	12	5	2	1	1	0	0	0	3	1	3	1	6	3	3	1
		P190	159	67	56	23	19	8	5	2	0	0	12	5	25	10	27	11	24	10
		P191	230	96	8	3	0	0	1	0	0	0	1	0	0	0	7	3	2	1
		P609			1		0		0		0		0		1		0		0	
		P636			2		0		0		0		2		0		0		0	
		P640			4		0		0		0		4		0		0		0	
		P648			1		0		0		0		1		0		0		0	
		P650			12		0		0		0		6		6		0		0	
	787	T094	649	82	111	14	20	3	7	1	0	0	32	4	49	6	45	6	27	3
		T095	395	50	237	30	102	13	45	6	8	1	96	12	146	19	176	22	123	16
		T103	646	82	124	16	13	2	4	1	0	0	29	4	45	6	41	5	33	4
		T105	370	47	232	29	128	16	48	6	9	1	118	15	162	21	173	22	144	18
		T117	302	38	234	30	159	20	80	10	12	2	180	23	222	28	195	25	176	22
		T118	744	95	41	5	2	0	0	0	0	0	8	1	8	1	9	1	15	2
		T127	744	95	41	5	2	0	0	0	0	0	2	0	13	2	20	3	6	1
		T129	686	87	95	12	6	1	0	0	0	0	16	2	18	2	33	4	26	3
		T135	703	89	45	6	27	3	10	1	2	0	29	4	22	3	43	5	27	3
		T139	697	89	78	10	10	1	2	0	0	0	39	5	33	4	17	2	11	1
		T143	351	45	245	31	128	16	51	6	12	2	128	16	180	23	168	21	157	20
		T144	416	53	256	33	91	12	21	3	3	0	87	11	135	17	133	17	112	14
		T152	621	79	99	13	39	5	15	2	13	2	69	9	82	10	70	9	36	5
		T163	614	78	141	18	26	3	6	1	0	0	35	4	42	5	63	8	51	6
		T164	727	92	53	7	7	1	0	0	0	0	22	3	14	2	14	2	11	1
		T165	779	99	8	1	0	0	0	0	0	0	0	0	2	0	1	0	5	1
		T169	766	97	17	2	4	1	0	0	0	0	8	1	5	1	7	1	2	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 07	373	F015	368	99	3	1	2	1	0	0	0	0	2	1	2	1	1	0	2	1
		F062	369	99	4	1	0	0	0	0	0	0	1	0	1	0	1	0	1	0
		F070	361	97	12	3	0	0	0	0	0	0	2	1	3	1	3	1	3	1
		F071	355	95	15	4	3	1	0	0	0	0	5	1	5	1	5	1	5	1
		F073	208	56	94	25	39	10	28	8	4	1	63	17	83	22	57	15	59	16
		F101	370	99	3	1	0	0	0	0	0	0	0	0	1	0	1	0	1	0
		F105	367	98	6	2	0	0	0	0	0	0	1	0	1	0	2	1	2	1
		F111	309	83	53	14	9	2	2	1	0	0	13	3	20	5	18	5	21	6
		F112	281	75	68	18	23	6	1	0	0	0	20	5	34	9	22	6	32	9
		F123	330	88	37	10	5	1	1	0	0	0	12	3	23	6	10	3	4	1
		F134	319	86	43	12	8	2	3	1	0	0	15	4	28	8	12	3	13	3
		F135	260	70	79	21	25	7	9	2	0	0	52	14	62	17	22	6	16	4
		F136	155	42	105	28	60	16	39	10	14	4	104	28	125	34	102	27	54	14
		F173	332	89	33	9	8	2	0	0	0	0	11	3	17	5	13	3	6	2
		F175	290	78	66	18	14	4	3	1	0	0	21	6	33	9	27	7	14	4
		F176	248	66	89	24	34	9	1	0	1	0	34	9	54	14	37	10	26	7
		F177	341	91	28	8	4	1	0	0	0	0	10	3	13	3	9	2	4	1
		F178	288	77	72	19	11	3	2	1	0	0	31	8	38	10	18	5	9	2
		F180	272	73	74	20	23	6	3	1	1	0	40	11	39	10	31	8	19	5
		F181	367	98	5	1	1	0	0	0	0	0	3	1	4	1	0	0	0	0
		F182	332	89	37	10	4	1	0	0	0	0	10	3	12	3	10	3	11	3
		F186	220	59	106	28	33	9	13	3	1	0	47	13	70	19	52	14	37	10
		F189	362	97	10	3	1	0	0	0	0	0	3	1	4	1	3	1	2	1
		F190	199	53	99	27	51	14	19	5	5	1	76	20	97	26	56	15	41	11
		F191	320	86	48	13	3	1	2	1	0	0	7	2	18	5	14	4	15	4
		F609			1		0		0		0		1		0		0		0	
		F636			12		0		0		0		7		5		0		0	
		F640			28		5		0		0		26		11		1		0	
		F648			12		1		0		0		12		2		0		0	
		F650			34		5		0		0		28		16		0		0	
	1046	T094	792	76	191	18	48	5	12	1	3	0	51	5	80	8	108	10	85	8
		T095	576	55	263	25	120	11	68	7	19	2	153	15	204	20	214	20	184	18
		T103	719	69	230	22	72	7	20	2	5	0	77	7	112	11	134	13	121	12
		T105	683	65	150	14	98	9	81	8	34	3	155	15	205	20	203	19	144	14
		T117	418	40	274	26	149	14	119	11	86	8	206	20	303	29	365	35	359	34
		T118	1000	96	44	4	2	0	0	0	0	0	11	1	17	2	11	1	8	1
		T127	847	81	176	17	22	2	1	0	0	0	25	2	41	4	63	6	85	8
		T129	722	69	249	24	66	6	9	1	0	0	49	5	106	10	132	13	108	10
		T135	951	91	78	7	14	1	3	0	0	0	29	3	16	2	37	4	27	3
		T139	590	56	319	30	112	11	24	2	1	0	87	8	119	11	198	19	195	19
		T143	573	55	267	26	131	13	57	5	18	2	144	14	198	19	223	21	180	17
		T144	653	62	268	26	102	10	19	2	4	0	80	8	122	12	183	17	142	14
		T152	866	83	56	5	47	4	47	4	30	3	89	9	116	11	106	10	89	9
		T163	802	77	185	18	46	4	12	1	1	0	55	5	70	7	97	9	88	8
		T164	1000	96	39	4	7	1	0	0	0	0	14	1	13	1	15	1	9	1
		T165	975	93	70	7	1	0	0	0	0	0	11	1	5	0	22	2	26	2
		T169	1042	100	4	0	0	0	0	0	0	0	2	0	0	0	0	0	2	0
		T309			1		0		0		0		0		0		0		0	
		T336			5		0		0		0		0		1		1		2	
		T340			5		1		2		0		0		1		5		3	
		T348			5		0		0		0		0		0		3		0	
		T350			1		3		0		0		0		0		3		2	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
IOWA	41	P071	38	93	2	5	1	2	0	0	0	0	1	2	0	0	3	7	0	0
		P073	27	66	11	27	2	5	1	2	0	0	10	24	2	5	4	10	2	5
		P111	34	83	5	12	2	5	0	0	0	0	2	5	4	10	0	0	3	7
		P112	31	76	7	17	3	7	0	0	0	0	3	7	6	15	1	2	3	7
		P123	39	95	2	5	0	0	0	0	0	0	1	2	0	0	1	2	0	0
		P134	39	95	2	5	0	0	0	0	0	0	0	0	1	2	1	2	0	0
		P135	35	85	6	15	0	0	0	0	0	0	3	7	2	5	1	2	0	0
		P136	32	78	7	17	1	2	1	2	0	0	1	2	7	17	2	5	2	5
		P175	39	95	2	5	0	0	0	0	0	0	1	2	0	0	1	2	0	0
		P176	39	95	2	5	0	0	0	0	0	0	1	2	0	0	1	2	0	0
		P178	35	85	6	15	0	0	0	0	0	0	0	0	5	12	0	0	0	0
		P180	37	90	4	10	0	0	0	0	0	0	0	0	1	2	3	7	0	0
		P182	37	90	4	10	0	0	0	0	0	0	2	5	1	2	1	2	0	0
		P186	24	59	14	34	3	7	0	0	0	0	7	17	9	22	3	7	0	0
		P189	40	98	1	2	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		P190	27	66	9	22	5	12	0	0	0	0	10	24	8	20	1	2	0	0
		P191	29	71	11	27	0	0	1	2	0	0	3	7	7	17	1	2	1	2
	417	T094	363	87	49	12	5	1	0	0	0	0	2	0	0	0	20	5	35	8
		T095	349	84	58	14	10	2	0	0	0	0	4	1	2	0	32	8	38	9
		T103	345	83	62	15	10	2	0	0	0	0	5	1	6	1	26	6	44	11
		T105	394	94	21	5	2	0	0	0	0	0	4	1	3	1	9	2	9	2
		T117	193	46	156	37	63	15	3	1	2	0	16	4	14	3	99	24	167	40
		T118	413	99	4	1	0	0	0	0	0	0	1	0	1	0	1	0	1	0
		T127	372	89	45	11	0	0	0	0	0	0	2	0	5	1	5	1	31	7
		T129	343	82	71	17	3	1	0	0	0	0	5	1	4	1	29	7	39	9
		T135	412	99	5	1	0	0	0	0	0	0	0	0	0	0	4	1	1	0
		T139	246	59	140	34	30	7	1	0	0	0	11	3	5	1	75	18	108	26
		T143	338	81	74	18	4	1	1	0	0	0	4	1	5	1	31	7	44	11
		T144	349	84	64	15	4	1	0	0	0	0	4	1	3	1	34	8	31	7
		T152	413	99	4	1	0	0	0	0	0	0	0	0	0	0	1	0	3	1
		T163	356	85	58	14	3	1	0	0	0	0	3	1	1	0	19	5	39	9
		T164	414	99	3	1	0	0	0	0	0	0	0	0	2	0	1	0	0	0
		T165	394	94	23	6	0	0	0	0	0	0	1	0	1	0	7	2	14	3
		T336			3		0		0		0		0		0		1		1	
		T340			3		0		1		0		0		1		1		2	
		T348			3		0		0		0		0		0		1		0	
		T350			1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
KANSAS	66	P015	65	98	0	0	1	2	0	0	0	0	1	2	0	0	1	2	0	0
		P070	65	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		P071	61	92	5	8	0	0	0	0	0	0	1	2	2	3	1	2	1	2
		P073	11	17	17	26	18	27	16	24	4	6	23	35	44	67	24	36	23	35
		P105	65	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
		P111	53	80	12	18	1	2	0	0	0	0	6	9	5	8	2	3	1	2
		P112	45	68	12	18	9	14	0	0	0	0	6	9	10	15	6	9	7	11
		P123	52	79	13	20	1	2	0	0	0	0	2	3	8	12	3	5	2	3
		P134	49	74	11	17	3	5	3	5	0	0	5	8	10	15	6	9	5	8
		P135	43	65	13	20	6	9	4	6	0	0	12	18	14	21	5	8	6	9
		P136	29	44	18	27	9	14	6	9	4	6	21	32	23	35	16	24	9	14
		P173	55	83	10	15	1	2	0	0	0	0	2	3	4	6	5	8	1	2
		P175	45	68	17	26	2	3	2	3	0	0	8	12	9	14	8	12	2	3
		P176	37	56	22	33	7	11	0	0	0	0	6	9	17	26	8	12	5	8
		P177	55	83	9	14	2	3	0	0	0	0	4	6	5	8	3	5	1	2
		P178	44	67	18	27	2	3	2	3	0	0	13	20	10	15	4	6	1	2
		P180	42	64	18	27	4	6	1	2	1	2	16	24	11	17	4	6	1	2
		P181	63	95	2	3	1	2	0	0	0	0	2	3	2	3	0	0	0	0
		P182	55	83	10	15	1	2	0	0	0	0	1	2	3	5	2	3	6	9
		P186	34	52	26	39	4	6	2	3	0	0	14	21	12	18	8	12	5	8
		P189	63	95	3	5	0	0	0	0	0	0	0	0	1	2	2	3	0	0
		P190	19	29	20	30	13	20	10	15	4	6	24	36	26	39	23	35	17	26
		P191	54	82	10	15	1	2	1	2	0	0	1	2	5	8	4	6	3	5
		P636			9		0		0		0		4		5		0		0	
		P640			15		5		0		0		13		11		1		0	
		P648			5		1		0		0		5		2		0		0	
		P650			15		4		0		0		10		13		0		0	
	317	T094	192	61	89	28	27	9	7	2	2	1	27	9	53	17	55	17	31	10
		T095	138	44	86	27	49	15	31	10	13	4	75	24	90	28	93	29	63	20
		T103	226	71	74	23	16	5	1	0	0	0	21	7	35	11	32	10	20	6
		T105	214	68	76	24	22	7	5	2	0	0	34	11	40	13	38	12	20	6
		T117	191	60	68	21	35	11	20	6	3	1	41	13	66	21	64	20	33	10
		T118	291	92	24	8	2	1	0	0	0	0	6	2	10	3	9	3	3	1
		T127	229	72	72	23	15	5	1	0	0	0	14	4	22	7	35	11	31	10
		T129	197	62	88	28	31	10	1	0	0	0	19	6	42	13	58	18	29	9
		T135	242	76	60	19	12	4	3	1	0	0	29	9	14	4	26	8	20	6
		T139	145	46	105	33	48	15	18	6	1	0	65	21	73	23	79	25	35	11
		T143	128	40	88	28	65	21	24	8	12	4	76	24	101	32	99	31	57	18
		T144	150	47	100	32	55	17	10	3	2	1	44	14	70	22	86	27	43	14
		T152	297	94	17	5	3	1	0	0	0	0	4	1	8	3	8	3	2	1
		T163	226	71	52	16	28	9	10	3	1	0	30	9	39	12	41	13	29	9
		T164	312	98	5	2	0	0	0	0	0	0	1	0	1	0	2	1	1	0
		T165	305	96	12	4	0	0	0	0	0	0	0	0	0	0	3	1	5	2
		T169	315	99	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1
		T336			1		0		0		0		0		0		0		1	
		T340			0		1		1		0		0		0		4		0	
		T348			2		0		0		0		0		0		2		0	
		T350			0		2		0		0		0		0		3		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MISSOURI	227	P015	223	98	3	1	1	0	0	0	0	0	1	0	2	1	0	0	2	1
		P062	226	100	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		P070	217	96	10	4	0	0	0	0	0	0	2	1	2	1	2	1	3	1
		P071	219	96	6	3	2	1	0	0	0	0	1	0	3	1	1	0	4	2
		P073	148	65	50	22	18	8	11	5	0	0	28	12	32	14	26	11	28	12
		P101	225	99	2	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0
		P105	224	99	3	1	0	0	0	0	0	0	0	0	0	0	2	1	1	0
		P111	198	87	27	12	2	1	0	0	0	0	2	1	4	2	10	4	12	5
		P112	173	76	43	19	10	4	1	0	0	0	11	5	16	7	15	7	18	8
		P123	211	93	12	5	3	1	1	0	0	0	5	2	11	5	4	2	1	0
		P134	206	91	17	7	4	2	0	0	0	0	7	3	13	6	4	2	1	0
		P135	161	71	46	20	16	7	4	2	0	0	32	14	37	16	13	6	4	2
		P136	90	40	67	30	41	18	22	10	7	3	65	29	76	33	65	29	28	12
		P173	204	90	19	8	4	2	0	0	0	0	8	4	10	4	5	2	3	1
		P175	179	79	38	17	10	4	0	0	0	0	11	5	16	7	15	7	9	4
		P176	151	67	54	24	20	9	1	0	1	0	24	11	28	12	22	10	17	7
		P177	213	94	12	5	2	1	0	0	0	0	4	2	6	3	4	2	2	1
		P178	184	81	35	15	8	4	0	0	0	0	13	6	19	8	10	4	6	3
		P180	165	73	44	19	16	7	2	1	0	0	23	10	20	9	18	8	18	8
		P181	225	99	2	1	0	0	0	0	0	0	1	0	1	0	0	0	0	0
		P182	211	93	16	7	0	0	0	0	0	0	5	2	4	2	3	1	2	1
		P186	139	61	57	25	19	8	11	5	1	0	23	10	39	17	36	16	28	12
		P189	222	98	4	2	1	0	0	0	0	0	3	1	2	1	1	0	0	0
		P190	126	56	61	27	30	13	9	4	1	0	40	18	59	26	28	12	20	9
		P191	207	91	18	8	2	1	0	0	0	0	3	1	4	2	5	3	8	4
		P636			2		0		0		0		2		0		0		0	
		P640			8		0		0		0		8		0		0		0	
		P648			1		0		0		0		1		0		0		0	
		P650			9		0		0		0		9		0		0		0	
	134	T094	90	67	28	21	11	8	4	3	1	1	16	12	18	13	20	15	10	7
		T095	55	41	44	33	19	14	15	11	1	1	23	17	45	34	29	22	26	19
		T103	99	74	26	19	5	4	4	3	0	0	8	6	9	7	20	15	10	7
		T105	64	48	32	24	22	16	14	10	2	1	22	16	30	22	36	27	29	22
		T117	33	25	44	33	30	22	19	14	8	6	33	25	56	42	56	42	34	25
		T118	126	94	8	6	0	0	0	0	0	0	0	0	3	2	0	0	4	3
		T127	112	84	21	16	1	1	0	0	0	0	2	1	3	2	7	5	7	5
		T129	95	71	27	20	10	7	2	1	0	0	9	7	14	10	12	9	13	10
		T135	124	93	9	7	1	1	0	0	0	0	0	0	1	1	4	3	4	3
		T139	59	44	46	34	24	18	5	4	0	0	7	5	23	17	39	29	35	26
		T143	47	35	43	32	32	24	12	9	0	0	16	12	37	28	41	31	35	26
		T144	73	54	41	31	16	12	4	3	0	0	14	10	22	16	25	19	17	13
		T152	127	95	7	5	0	0	0	0	0	0	2	1	5	4	0	0	0	0
		T163	99	74	25	19	9	7	1	1	0	0	8	6	14	10	13	10	10	7
		T164	121	90	12	9	1	1	0	0	0	0	2	1	2	1	5	4	4	3
		T165	115	86	19	14	0	0	0	0	0	0	1	1	3	2	8	6	5	4
		T309			1		0		0		0		0		0		0		0	
		T336			1		0		0		0		0		1		0		0	
		T340			2		0		0		0		0		0		0		1	
		T350			0		1		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NEBRASKA	39	F062	36	92	3	8	0	0	0	0	0	0	1	3	0	0	1	3	1	3
		F070	38	97	1	3	0	0	0	0	0	0	0	0	1	3	0	0	0	0
		F071	37	95	2	5	0	0	0	0	0	0	2	5	0	0	0	0	0	0
		F073	22	56	16	41	1	3	0	0	0	0	2	5	5	13	3	8	6	15
		F101	38	97	1	3	0	0	0	0	0	0	0	0	1	3	0	0	0	0
		F105	37	95	2	5	0	0	0	0	0	0	1	3	1	3	0	0	0	0
		F111	24	62	9	23	4	10	2	5	0	0	3	8	7	18	6	15	5	13
		F112	32	82	6	15	1	3	0	0	0	0	0	0	2	5	0	0	4	10
		F123	28	72	10	26	1	3	0	0	0	0	4	10	4	10	2	5	1	3
		F134	25	64	13	33	1	3	0	0	0	0	3	8	4	10	1	3	7	18
		F135	21	54	14	36	3	8	1	3	0	0	5	13	9	23	3	8	6	15
		F136	4	10	13	33	9	23	10	26	3	8	17	44	19	49	19	49	15	38
		F173	32	82	4	10	3	8	0	0	0	0	1	3	3	8	3	8	2	5
		F175	27	69	9	23	2	5	1	3	0	0	1	3	8	21	3	8	3	8
		F176	21	54	11	28	7	18	0	0	0	0	3	8	9	23	6	15	4	10
		F177	32	82	7	18	0	0	0	0	0	0	2	5	2	5	2	5	1	3
		F178	25	64	13	33	1	3	0	0	0	0	5	13	4	10	4	10	2	5
		F180	28	72	8	21	3	8	0	0	0	0	1	3	7	18	6	15	0	0
		F181	38	97	1	3	0	0	0	0	0	0	0	0	1	3	0	0	0	0
		F182	29	74	7	18	3	8	0	0	0	0	2	5	4	10	4	10	3	8
		F186	23	59	9	23	7	18	0	0	0	0	3	8	10	26	5	13	4	10
		F189	37	95	2	5	0	0	0	0	0	0	0	0	0	0	0	0	2	5
		F190	27	69	9	23	3	8	0	0	0	0	2	5	4	10	4	10	4	10
		F191	30	77	9	23	0	0	0	0	0	0	0	0	2	5	3	8	3	8
		F609			1		0		0		0		1		0		0		0	
		F636			1		0		0		0		1		0		0		0	
		F640			5		0		0		0		5		0		0		0	
		F648			6		0		0		0		6		0		0		0	
		F650			10		1		0		0		9		3		0		0	
	178	T094	147	83	25	14	5	3	1	1	0	0	6	3	9	5	13	7	9	5
		T095	34	19	75	42	42	24	22	12	5	3	51	29	67	38	60	34	57	32
		T103	49	28	68	38	41	23	15	8	5	3	43	24	62	35	56	31	47	26
		T105	11	6	21	12	52	29	62	35	32	18	95	53	132	74	120	67	86	48
		T117	1	1	6	3	21	12	77	43	73	41	116	65	167	94	146	82	125	70
		T118	170	96	8	4	0	0	0	0	0	0	4	2	3	2	1	1	0	0
		T127	134	75	38	21	6	3	0	0	0	0	7	4	11	6	16	9	16	9
		T129	87	49	63	35	22	12	6	3	0	0	16	9	46	26	33	19	27	15
		T135	173	97	4	2	1	1	0	0	0	0	0	0	1	1	3	2	2	1
		T139	140	79	28	16	10	6	0	0	0	0	4	2	18	10	5	3	17	10
		T143	60	34	62	35	30	17	20	11	6	3	48	27	55	31	52	29	44	25
		T144	81	46	63	35	27	15	5	3	2	1	18	10	27	15	38	21	51	29
		T152	29	16	28	16	44	25	47	26	30	17	83	47	103	58	97	54	84	47
		T163	121	68	50	28	6	3	1	1	0	0	14	8	16	9	24	13	10	6
		T164	153	86	19	11	6	3	0	0	0	0	11	6	8	4	7	4	4	2
		T165	161	90	16	9	1	1	0	0	0	0	9	5	1	1	4	2	2	1
		T169	176	99	2	1	0	0	0	0	0	0	2	1	0	0	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 08	432	F015	363	84	54	13	14	3	1	0	0	0	31	7	30	7	12	3	8	2
		F062	427	99	5	1	0	0	0	0	0	0	2	0	1	0	0	0	1	0
		F070	391	91	38	9	3	1	0	0	0	0	17	4	18	4	4	1	4	1
		F071	414	96	18	4	0	0	0	0	0	0	3	1	8	2	3	1	2	0
		F073	317	73	100	23	14	3	1	0	0	0	59	14	45	10	19	4	4	1
		F101	422	98	10	2	0	0	0	0	0	0	2	0	4	1	1	0	2	0
		F105	412	95	17	4	3	1	0	0	0	0	6	1	9	2	1	0	5	1
		F111	288	67	103	24	26	6	12	3	3	1	37	9	58	13	52	12	37	9
		F112	302	70	89	21	25	6	14	3	2	0	43	10	53	12	44	10	36	8
		F123	380	88	48	11	4	1	0	0	0	0	12	3	27	6	7	2	4	1
		F134	361	84	60	14	10	2	1	0	0	0	23	5	23	5	15	3	11	3
		F135	281	65	105	24	34	8	9	2	3	1	68	16	73	17	39	9	19	4
		F136	168	39	125	29	79	18	48	11	12	3	119	28	154	36	99	23	77	18
		F173	338	78	78	18	14	3	2	0	0	0	34	8	31	7	29	7	12	3
		F175	284	66	108	25	29	7	10	2	1	0	65	15	53	12	53	12	18	4
		F176	169	39	156	36	74	17	27	6	6	1	113	26	116	27	93	22	52	12
		F177	371	86	50	12	10	2	1	0	0	0	22	5	22	5	16	4	12	3
		F178	250	58	125	29	47	11	7	2	3	1	68	16	78	18	55	13	39	9
		F180	268	62	113	26	41	9	10	2	0	0	53	12	64	15	66	15	36	8
		F181	405	94	26	6	1	0	0	0	0	0	5	1	7	2	4	1	7	2
		F182	378	88	49	11	5	1	0	0	0	0	15	3	16	4	10	2	13	3
		F186	202	47	122	28	60	14	35	8	13	3	71	16	123	28	94	22	69	16
		F189	390	90	37	9	5	1	0	0	0	0	10	2	13	3	8	2	7	2
		F190	196	45	119	28	72	17	36	8	9	2	85	20	121	28	93	22	70	16
		F191	344	80	69	16	17	4	2	0	0	0	18	4	34	8	21	5	22	5
		F609			2		0		0		0		2		0		0		0	
		F636			68		2		0		0		67		5		0		0	
		F640			49		1		0		0		47		3		0		1	
		F648			34		1		0		0		32		3		0		1	
		F650			56		2		0		0		53		6		0		1	
	153	T094	66	43	47	31	21	14	14	9	5	3	22	14	32	21	40	26	44	29
		T095	45	29	52	34	49	32	6	4	1	1	28	18	41	27	46	30	41	27
		T103	88	58	44	29	19	12	2	1	0	0	18	12	19	12	24	16	21	14
		T105	60	39	45	29	30	20	16	10	2	1	26	17	44	29	41	27	37	24
		T117	44	29	49	32	29	19	24	16	7	5	42	27	51	33	46	30	40	26
		T118	149	97	4	3	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		T127	103	67	36	24	11	7	3	2	0	0	13	8	13	8	24	16	14	9
		T129	82	54	48	31	19	12	4	3	0	0	23	15	19	12	22	14	23	15
		T135	128	84	20	13	5	3	0	0	0	0	10	7	8	5	5	3	3	2
		T139	75	49	45	29	27	18	4	3	2	1	16	10	31	20	32	21	28	18
		T143	56	37	50	33	32	21	11	7	4	3	26	17	45	29	41	27	34	22
		T144	63	41	49	32	32	21	9	6	0	0	33	22	34	22	32	21	29	19
		T152	132	86	18	12	3	2	0	0	0	0	8	5	6	4	3	2	2	1
		T163	91	59	51	33	8	5	3	2	0	0	20	13	18	12	11	7	13	8
		T164	139	91	12	8	1	1	1	1	0	0	4	3	5	3	3	2	2	1
		T165	136	89	16	10	1	1	0	0	0	0	1	1	6	4	3	2	5	3
		T169	152	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T309			1		0		0		0		0		0		0		1	
		T336			2		0		0		0		1		1		0		0	
		T340			1		0		0		0		0		0		1		0	
		T350			2		0		0		0		0		0		2		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
COLORADO	156	F015	127	81	22	14	6	4	1	[illegible]	0	0	13	8	16	10	6	4	1	1
		F062	154	99	2	1	0	0	0	0	0	0	2	1	0	0	0	0	0	0
		F070	152	97	4	3	0	0	0	0	0	0	2	1	2	1	0	0	0	0
		F071	153	98	3	2	0	0	0	0	0	0	2	1	0	0	1	1	0	0
		F073	147	94	8	5	0	0	1	1	0	0	4	3	4	3	3	2	0	0
		F101	154	99	2	1	0	0	0	0	0	0	0	0	1	1	1	1	0	0
		F105	153	98	1	1	2	1	0	0	0	0	2	1	2	1	1	1	0	0
		F111	105	67	38	24	6	4	6	4	1	1	13	8	19	12	25	16	6	4
		F112	120	77	26	17	5	3	4	3	1	1	11	7	13	8	21	13	4	3
		F123	132	85	22	14	2	1	0	0	0	0	7	4	10	6	5	3	2	1
		F134	129	83	21	13	6	4	0	0	0	0	11	7	8	5	8	5	3	2
		F135	92	59	49	31	14	9	1	1	0	0	25	16	23	15	19	12	5	3
		F136	66	42	62	40	19	12	8	5	1	1	37	24	46	29	34	22	6	4
		F173	111	71	36	23	7	4	2	1	0	0	18	12	13	8	17	11	6	4
		F175	87	56	46	29	15	10	7	4	1	1	29	19	30	19	30	19	8	5
		F176	68	44	53	34	25	16	6	4	4	3	43	28	35	22	41	26	12	8
		F177	133	85	16	10	6	4	1	1	0	0	13	8	7	4	10	6	1	1
		F178	99	63	42	27	11	7	2	1	2	1	26	17	23	15	20	13	5	3
		F180	96	62	43	28	12	8	5	3	0	0	18	12	18	12	35	22	9	6
		F181	154	99	2	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		F182	153	98	3	2	0	0	0	0	0	0	1	1	1	1	1	1	0	0
		F186	116	74	36	23	2	1	2	1	0	0	4	3	11	7	16	10	4	3
		F189	148	95	7	4	1	1	0	0	0	0	3	2	2	1	2	1	0	0
		F190	108	69	39	25	6	4	3	2	0	0	12	8	18	12	19	12	3	2
		F191	150	96	6	4	0	0	0	0	0	0	1	1	2	1	1	1	0	0
		F636			17		0		0		0		16		1		0		0	
		F640			13		1		0		0		13		2		0		0	
		F648			19		1		0		0		19		2		0		0	
		F650			22		2		0		0		23		3		0		0	
	32	T094	24	75	7	22	1	3	0	0	0	0	1	3	2	6	4	13	2	6
		T095	14	44	12	38	6	19	0	0	0	0	4	13	8	25	8	25	3	9
		T103	20	63	9	28	2	6	1	3	0	0	5	16	5	16	5	16	1	3
		T105	18	56	7	22	3	9	3	9	1	3	6	19	11	34	5	16	4	13
		T117	9	28	10	31	7	22	3	9	3	9	10	31	17	53	6	19	2	6
		T118	31	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T127	29	91	3	9	0	0	0	0	0	0	1	3	1	3	0	0	0	0
		T129	19	59	8	25	5	16	0	0	0	0	7	22	3	9	4	13	1	3
		T135	29	91	3	9	0	0	0	0	0	0	1	3	0	0	1	3	0	0
		T139	20	63	10	31	2	6	0	0	0	0	0	0	3	9	5	16	5	16
		T143	15	47	11	34	5	16	1	3	0	0	2	6	9	28	8	25	2	6
		T144	22	69	9	28	1	3	0	0	0	0	2	6	1	3	3	9	1	3
		T152	23	72	7	22	2	6	0	0	0	0	3	9	6	19	0	0	0	0
		T163	14	44	14	44	3	9	1	3	0	0	4	13	9	28	5	16	1	3
		T164	29	91	3	9	0	0	0	0	0	0	2	6	1	3	0	0	0	0
		T165	29	91	2	6	1	3	0	0	0	0	0	0	1	3	0	0	1	3
		T309			1		0		0		0		0		0		0		1	
		T340			1		0		0		0		0		0		1		0	
		T350			1		0		0		0		0		0		1		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
MONTANA	83	P015	67	81	12	14	4	5	0	0	0	0	8	10	8	10	3	4	1	1
		P070	81	98	2	2	0	0	0	0	0	0	0	0	2	2	0	0	0	0
		P071	77	93	6	7	0	0	0	0	0	0	0	0	2	2	2	2	0	0
		P073	37	45	44	53	2	2	0	0	0	0	34	41	12	14	1	1	0	0
		P105	82	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		P111	68	82	12	14	3	4	0	0	0	0	3	4	6	7	6	7	1	1
		P112	67	81	10	12	6	7	0	0	0	0	4	5	6	7	5	6	5	6
		P123	77	93	5	6	1	1	0	0	0	0	3	4	4	5	0	0	0	0
		P134	71	86	11	13	1	1	0	0	0	0	6	7	6	7	0	0	1	1
		P135	64	77	17	20	2	2	0	0	0	0	6	7	11	13	3	4	1	1
		P136	67	81	12	14	4	5	0	0	0	0	6	7	4	5	7	8	1	1
		P175	77	93	6	7	0	0	0	0	0	0	1	1	4	5	1	1	0	0
		P176	47	57	28	34	6	7	2	2	0	0	12	14	11	13	9	11	5	6
		P178	56	67	24	29	3	4	0	0	0	0	7	8	9	11	13	16	0	0
		P180	79	95	1	1	3	4	0	0	0	0	2	2	4	5	1	1	0	0
		P181	82	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		P182	79	95	4	5	0	0	0	0	0	0	1	1	1	1	1	1	0	0
		P186	54	65	26	31	3	4	0	0	0	0	9	11	13	16	5	6	1	1
		P189	80	96	3	4	0	0	0	0	0	0	1	1	0	0	1	1	0	0
		P190	44	53	27	33	11	13	1	1	0	0	14	17	14	17	15	18	4	5
		P191	70	84	11	13	2	2	0	0	0	0	3	4	4	5	2	2	2	2
		P636			16		0		0		0		16		0		0		0	
		P648			1		0		0		0		1		0		0		0	
		P650			1		0		0		0		1		0		0		0	
	11	T094	4	36	6	55	1	9	0	0	0	0	3	27	0	0	2	[illegible]	2	18
		T095	10	91	1	9	0	0	0	0	0	0	0	0	0	0	1	9	0	0
		T117	2	18	4	36	2	18	3	27	0	0	4	36	3	27	4	36	3	27
		T127	8	73	3	27	0	0	0	0	0	0	1	9	1	9	1	9	0	0
		T129	6	55	5	45	0	0	0	0	0	0	1	9	1	9	2	18	0	0
		T135	10	91	1	9	0	0	0	0	0	0	0	0	1	9	0	0	0	0
		T139	2	18	5	45	3	27	1	9	0	0	2	18	7	64	2	18	0	0
		T143	5	45	4	36	2	18	0	0	0	0	1	9	2	18	4	36	1	9
		T144	7	64	4	36	0	0	0	0	0	0	0	0	3	27	1	9	0	0
		T163	7	64	3	27	1	9	0	0	0	0	3	27	0	0	0	0	0	0
		T165	10	91	1	9	0	0	0	0	0	0	0	0	1	9	0	0	0	0
		T169	10	91	1	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T336			1		0		0		0		1		0		0		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NORTH DAKOTA	59	P015	48	81	10	17	1	2	0	0	0	0	1	2	1	2	3	5	4	7
		P062	57	97	2	3	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		P070	33	56	23	39	3	5	0	0	0	0	11	19	12	20	3	5	3	5
		P071	55	93	4	7	0	0	0	0	0	0	0	0	3	5	0	0	1	2
		P073	39	66	16	27	4	7	0	0	0	0	2	3	7	12	10	17	4	7
		P111	41	69	15	25	1	2	1	2	1	2	4	7	6	10	6	10	5	8
		P112	44	75	13	22	0	0	2	3	0	0	2	3	8	14	4	7	3	5
		P123	57	97	2	3	0	0	0	0	0	0	0	0	1	2	0	0	1	2
		P134	49	83	8	14	1	2	1	2	0	0	2	3	4	7	2	3	4	7
		P135	51	86	8	14	0	0	0	0	0	0	4	7	1	2	1	2	2	3
		P136	4	7	12	20	26	44	10	17	7	12	25	42	40	68	24	41	20	34
		P173	48	81	10	17	1	2	0	0	0	0	0	0	5	8	2	3	3	5
		P175	38	64	17	29	3	5	1	2	0	0	8	14	6	10	6	10	3	5
		P176	13	22	21	36	19	32	5	8	1	2	10	17	25	42	17	29	13	22
		P177	51	86	7	12	1	2	0	0	0	0	2	3	2	3	2	3	2	3
		P178	38	64	15	25	5	8	1	2	0	0	10	17	5	8	6	10	4	7
		P180	38	64	15	25	5	8	1	2	0	0	8	14	7	12	7	12	3	5
		P181	50	85	8	14	1	2	0	0	0	0	0	0	1	2	2	3	5	8
		P182	36	61	22	37	1	2	0	0	0	0	4	7	4	7	7	12	5	8
		P186	5	8	19	32	21	36	12	20	2	3	19	32	35	59	21	36	18	31
		P189	52	88	7	12	0	0	0	0	0	0	1	2	0	0	1	2	4	7
		P190	11	19	17	29	21	36	7	12	3	5	18	31	22	37	18	31	22	37
		P191	34	58	19	32	6	10	0	0	0	0	5	8	5	8	8	14	10	17
		P636			1		0		0		0		0		1		0		0	
		P640			2		0		0		0		2		0		0		0	
		P648			1		0		0		0		1		0		0		0	
		P650			4		0		0		0		4		0		0		0	
	23	T094	20	87	3	13	0	0	0	0	0	0	0	0	1	4	1	4	0	0
		T095	9	39	7	30	6	26	1	4	0	0	2	9	5	22	9	39	3	13
		T103	18	78	4	17	1	4	0	0	0	0	0	0	0	0	3	13	1	4
		T105	15	65	6	26	2	9	0	0	0	0	1	4	3	13	3	13	2	9
		T117	4	17	8	35	4	17	7	30	0	0	8	35	10	43	9	39	2	9
		T127	19	83	3	13	1	4	0	0	0	0	0	0	1	4	4	17	0	0
		T129	14	61	8	35	0	0	1	4	0	0	2	9	1	4	5	22	1	4
		T135	22	96	1	4	0	0	0	0	0	0	0	0	1	4	0	0	0	0
		T139	12	52	6	26	5	22	0	0	0	0	3	13	3	13	6	26	2	9
		T143	6	26	11	48	5	22	1	4	0	0	3	13	8	35	3	13	3	13
		T144	6	26	14	61	3	13	0	0	0	0	8	35	6	26	4	17	1	4
		T152	17	74	6	26	0	0	0	0	0	0	4	17	0	0	1	4	0	0
		T163	19	83	4	17	0	0	0	0	0	0	1	4	0	0	0	0	0	0
		T164	21	91	2	9	0	0	0	0	0	0	0	0	0	0	1	4	1	4
		T165	22	96	1	4	0	0	0	0	0	0	0	0	0	0	1	4	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
SOUTH DAKOTA	67	F015	66	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F062	66	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		F070	59	88	8	12	0	0	0	0	0	0	3	4	2	3	1	1	1	1
		F071	64	96	3	4	0	0	0	0	0	0	1	1	2	3	0	0	0	0
		F073	54	81	11	16	2	3	0	0	0	0	3	4	9	13	3	4	0	0
		F101	66	99	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
		F105	62	93	5	7	0	0	0	0	0	0	1	1	4	6	0	0	0	0
		F111	43	64	15	22	7	10	2	3	0	0	3	4	8	12	7	10	15	22
		F112	40	60	18	27	6	9	3	4	0	0	7	10	11	16	6	9	12	18
		F123	65	97	2	3	0	0	0	0	0	0	0	0	1	1	0	0	1	1
		F134	62	93	5	7	0	0	0	0	0	0	0	0	1	1	0	0	2	3
		F135	58	87	9	13	0	0	0	0	0	0	2	3	5	7	0	0	2	3
		F136	12	18	16	24	13	19	22	33	4	6	22	33	32	48	21	31	45	67
		F173	54	81	11	16	2	3	0	0	0	0	4	6	3	4	5	7	3	4
		F175	44	66	16	24	6	9	1	1	0	0	10	15	5	7	9	13	7	10
		F176	18	27	28	42	11	16	9	13	1	1	20	30	22	33	16	24	20	30
		F177	49	73	17	25	1	1	0	0	0	0	3	4	4	6	3	4	9	13
		F178	20	30	20	30	22	33	4	6	1	1	11	16	22	33	13	19	30	45
		F180	25	37	28	42	12	18	2	3	0	0	8	12	14	21	13	19	22	33
		F181	61	91	6	9	0	0	0	0	0	0	1	1	2	3	1	1	2	3
		F182	56	84	7	10	4	6	0	0	0	0	2	3	5	7	0	0	8	12
		F186	6	9	23	34	16	24	13	19	9	13	21	31	37	55	30	45	34	51
		F189	58	87	7	10	2	3	0	0	0	0	3	4	5	7	1	1	2	3
		F190	16	24	17	25	15	22	15	22	4	6	15	22	32	48	24	36	32	48
		F191	36	54	23	34	6	9	2	3	0	0	7	10	18	27	7	10	9	13
		F609			1		0		0		0		1		0		0		0	
		F636			5		1		0		0		6		1		0		0	
		F640			5		0		0		0		4		0		0		1	
		F648			1		0		0		0		0		0		0		1	
		F650			6		0		0		0		4		1		0		1	
	48	T094	14	29	20	42	11	23	2	4	1	2	6	13	8	17	14	29	21	44
		T095	5	10	16	33	23	48	4	8	0	0	2	4	10	21	21	44	32	67
		T103	22	46	17	35	9	19	0	0	0	0	4	8	6	13	9	19	14	29
		T105	9	19	18	38	11	23	9	19	1	2	8	17	13	27	19	40	27	56
		T117	10	21	16	33	13	27	8	17	1	2	12	25	12	25	18	38	26	54
		T118	47	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T127	18	38	20	42	8	17	2	4	0	0	10	21	9	19	14	29	9	19
		T129	30	63	10	21	7	15	1	2	0	0	7	15	4	8	7	15	9	19
		T135	37	77	7	15	4	8	0	0	0	0	5	10	4	8	4	8	2	4
		T139	15	31	15	31	15	31	1	2	2	4	7	15	13	27	15	31	18	38
		T143	7	15	15	31	14	29	8	17	4	8	12	25	22	46	23	48	22	46
		T144	12	25	13	27	16	33	7	15	0	0	10	21	13	27	19	40	20	42
		T152	44	92	3	6	1	2	0	0	0	0	1	2	0	0	0	0	2	4
		T163	31	65	15	31	0	0	2	4	0	0	4	8	1	2	4	8	10	21
		T164	44	92	2	4	1	2	1	2	0	0	1	2	2	4	2	4	1	2
		T165	43	90	5	10	0	0	0	0	0	0	0	0	0	0	1	2	4	8

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
UTAH	45	F015	42	93	3	7	0	0	0	0	0	0	2	4	1	2	0	0	0	0
		F071	43	96	2	4	0	0	0	0	0	0	0	0	1	2	0	0	1	2
		F073	24	53	15	33	6	13	0	0	0	0	11	24	12	27	2	4	0	0
		F101	41	91	4	9	0	0	0	0	0	0	0	0	2	4	0	0	1	2
		F105	37	82	7	16	1	2	0	0	0	0	0	0	3	7	0	0	4	9
		F111	19	42	13	29	9	20	3	7	1	2	10	22	15	33	8	18	8	18
		F112	22	49	14	31	6	13	3	7	0	0	9	20	8	18	5	11	10	22
		F123	35	78	9	20	1	2	0	0	0	0	0	0	7	16	0	0	0	0
		F134	31	69	12	27	2	4	0	0	0	0	3	7	4	9	3	7	1	2
		F135	12	27	14	31	13	29	3	7	3	7	17	38	21	47	9	20	9	20
		F136	5	11	15	33	17	38	8	18	0	0	24	53	30	67	13	29	4	9
		F173	21	47	20	44	4	9	0	0	0	0	11	24	10	22	5	11	0	0
		F175	18	40	21	47	5	11	1	2	0	0	16	36	8	18	6	13	0	0
		F176	9	20	20	44	11	24	5	11	0	0	22	49	21	47	8	18	2	4
		F177	35	78	8	18	2	4	0	0	0	0	3	7	9	20	0	0	0	0
		F178	22	49	18	40	5	11	0	0	0	0	10	22	16	36	2	4	0	0
		F180	17	38	18	40	8	18	2	4	0	0	14	31	19	42	6	13	1	2
		F181	40	89	5	11	0	0	0	0	0	0	1	2	2	4	0	0	0	0
		F182	36	80	9	20	0	0	0	0	0	0	4	9	4	9	1	2	0	0
		F186	8	18	13	29	16	36	6	13	2	4	13	29	25	56	17	38	9	20
		F189	32	71	11	24	2	4	0	0	0	0	1	2	6	13	2	4	1	2
		F190	6	13	12	27	15	33	10	22	2	4	21	47	29	64	15	33	7	16
		F191	35	78	8	18	2	4	0	0	0	0	1	2	3	7	2	4	1	2
		F609			1		0		0		0		1		0		0		0	
		F636			17		1		0		0		17		2		0		0	
		F640			26		0		0		0		25		1		0		0	
		F648			12		0		0		0		11		1		0		0	
		F650			20		0		0		0		19		2		0		0	
	33	T094	3	9	11	33	8	24	8	24	3	9	7	21	15	45	15	45	18	55
		T095	5	15	14	42	13	39	1	3	0	0	17	52	15	45	5	15	3	9
		T103	16	48	11	33	6	18	0	0	0	0	5	15	6	18	5	15	5	15
		T105	7	21	12	36	10	30	4	12	0	0	7	21	14	42	11	33	4	12
		T117	19	58	11	33	2	6	0	0	1	3	1	3	3	9	4	12	6	18
		T118	32	97	1	3	0	0	0	0	0	0	0	0	1	3	0	0	0	0
		T127	24	73	6	18	2	6	1	3	0	0	0	0	1	3	5	15	5	15
		T129	12	36	13	39	6	18	2	6	0	0	3	9	9	27	3	9	11	33
		T135	24	73	8	24	1	3	0	0	0	0	4	12	2	6	0	0	1	3
		T139	22	67	9	27	0	0	2	6	0	0	3	9	4	12	3	9	2	6
		T143	20	61	6	18	6	18	1	3	0	0	7	21	4	12	2	6	5	15
		T144	10	30	9	27	12	36	2	6	0	0	13	39	11	33	5	15	7	21
		T163	18	55	13	39	2	6	0	0	0	0	5	15	6	18	1	3	2	6
		T164	28	85	5	15	0	0	0	0	0	0	1	3	2	6	0	0	0	0
		T165	26	79	7	21	0	0	0	0	0	0	1	3	4	12	1	3	0	0
		T336			1		0		0		0		0		1		0		0	
		T350			1		0		0		0		0		0		1		0	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
WYOMING	22	F015	13	59	6	27	3	14	0	0	0	0	7	32	4	18	0	0	1	5
		F070	21	95	1	5	0	0	0	0	0	0	1	5	0	0	0	0	0	0
		F073	16	73	6	27	0	0	0	0	0	0	5	23	1	5	0	0	0	0
		F101	19	86	3	14	0	0	0	0	0	0	2	9	0	0	0	0	1	5
		F105	19	86	3	14	0	0	0	0	0	0	2	9	0	0	0	0	1	5
		F111	12	55	10	45	0	0	0	0	0	0	4	18	4	18	0	0	2	9
		F112	9	41	8	36	2	9	2	9	1	5	10	45	7	32	3	14	2	9
		F123	14	64	8	36	0	0	0	0	0	0	2	9	4	18	2	9	0	0
		F134	19	86	3	14	0	0	0	0	0	0	1	5	0	0	2	9	0	0
		F135	4	18	8	36	5	23	5	23	0	0	14	64	12	55	7	32	0	0
		F136	14	64	8	36	0	0	0	0	0	0	5	23	2	9	0	0	1	5
		F173	21	95	1	5	0	0	0	0	0	0	1	5	0	0	0	0	0	0
		F175	20	91	2	9	0	0	0	0	0	0	1	5	0	0	1	5	0	0
		F176	14	64	6	27	2	9	0	0	0	0	6	27	2	9	2	9	0	0
		F177	20	91	2	9	0	0	0	0	0	0	1	5	0	0	1	5	0	0
		F178	15	68	6	27	1	5	0	0	0	0	4	18	3	14	1	5	0	0
		F180	13	59	8	36	1	5	0	0	0	0	3	14	2	9	4	18	1	5
		F181	18	82	4	18	0	0	0	0	0	0	2	9	2	9	0	0	0	0
		F182	18	82	4	18	0	0	0	0	0	0	3	14	1	5	0	0	0	0
		F186	13	59	5	23	2	9	2	9	0	0	5	23	2	9	5	23	3	14
		F189	20	91	2	9	0	0	0	0	0	0	1	5	0	0	1	5	0	0
		F190	11	50	7	32	4	18	0	0	0	0	5	23	6	27	2	9	2	9
		F191	19	86	2	9	1	5	0	0	0	0	1	5	2	9	1	5	0	0
		F636			12		0		0		0		12		0		0		0	
		F640			3		0		0		0		3		0		0		0	
		F650			3		0		0		0		3		0		0		0	
	6	T094	1	17	0	0	0	0	4	67	1	17	5	83	6	100	4	67	1	17
		T095	2	33	2	33	1	17	0	0	1	17	3	50	3	50	2	33	0	0
		T103	1	17	3	50	1	17	1	17	0	0	4	67	2	33	2	33	0	0
		T105	0	0	2	33	4	67	0	0	0	0	4	67	3	50	3	50	0	0
		T117	0	0	0	0	1	17	3	50	2	33	7	117	6	100	5	83	1	17
		T118	5	83	1	17	0	0	0	0	0	0	1	17	0	0	0	0	0	0
		T127	5	83	1	17	0	0	0	0	0	0	1	17	0	0	0	0	0	0
		T129	1	17	4	67	1	17	0	0	0	0	3	50	1	17	1	17	1	17
		T139	4	67	0	0	2	33	0	0	0	0	1	17	1	17	1	17	1	17
		T143	3	50	3	50	0	0	0	0	0	0	1	17	0	0	1	17	1	17
		T152	4	67	2	33	0	0	0	0	0	0	0	0	0	0	2	33	0	0
		T163	2	33	2	33	2	33	0	0	0	0	3	50	2	33	1	17	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 09	1268	P015	1224	97	42	3	2	0	0	0	0	0	6	0	14	1	11	1	11	1
		P015	1144	90	110	9	13	1	1	0	0	0	22	2	35	3	43	3	31	2
		P070	1246	98	21	2	1	0	0	0	0	0	3	0	6	0	7	1	6	0
		P071	1233	97	33	3	2	0	0	0	0	0	7	1	7	1	9	1	9	1
		P073	1141	90	100	8	21	2	5	0	1	0	39	3	47	4	36	3	30	2
		P101	1263	100	4	0	1	0	0	0	0	0	0	0	1	0	2	0	2	0
		P105	1230	97	38	3	0	0	0	0	0	0	2	0	8	1	13	1	11	1
		P111	1073	85	167	13	24	2	4	0	0	0	39	3	57	4	52	4	49	4
		P112	934	74	265	21	58	5	11	1	0	0	92	7	103	8	99	8	87	7
		P123	1138	90	106	8	22	2	2	0	0	0	23	2	41	3	39	3	37	3
		P134	903	71	269	21	77	6	14	1	5	0	85	7	116	9	122	10	128	10
		P135	863	68	289	23	94	7	17	1	5	0	107	8	129	10	129	10	130	10
		P136	163	13	248	20	300	24	299	24	258	20	598	47	742	59	674	53	541	43
		P173	932	74	260	21	61	5	13	1	2	0	53	4	74	6	120	9	134	11
		P175	553	44	442	35	207	16	56	4	10	1	229	18	272	21	261	21	206	16
		P176	516	41	416	33	223	18	91	7	22	2	190	15	233	18	327	26	326	26
		P177	1047	83	178	14	36	3	6	0	1	0	52	4	75	6	65	5	58	5
		P178	617	49	419	33	168	13	54	4	10	1	229	18	260	21	227	18	169	13
		P180	573	45	410	32	197	16	73	6	15	1	223	18	299	24	262	21	215	17
		P180	810	64	338	27	93	7	18	1	9	1	120	9	142	11	159	13	132	10
		P181	1180	93	85	7	3	0	0	0	0	0	22	2	23	2	21	2	19	1
		P182	1222	96	44	3	2	0	0	0	0	0	13	1	8	1	7	1	11	1
		P189	1104	87	134	11	27	2	3	0	0	0	25	2	38	3	59	5	59	5
		P190	471	37	437	34	245	19	87	7	28	2	222	18	287	23	321	25	323	25
		P191	1155	91	102	8	11	1	0	0	0	0	20	2	28	2	32	3	28	2
		P609	1266		2		0		0		0		2		0		0		0	
		P636	1267		1		0		0		0		3		0		0		0	
		P640	1261		7		0		0		0		7		0		0		0	
		P648	1262		6		0		0		0		6		0		0		0	
		P650	1258		10		0		0		0		7		2		1		0	
	111	T094	100	90	10	9	1	1	0	0	0	0	0	0	3	3	7	6	0	0
		T095	92	83	14	13	3	3	2	2	0	0	5	5	4	4	6	5	7	6
		T103	88	79	18	16	4	4	1	1	0	0	2	2	7	6	7	6	9	8
		T105	97	87	9	8	4	4	1	1	0	0	3	3	5	5	6	5	4	4
		T117	65	59	23	21	18	16	5	5	0	0	6	5	19	17	22	20	17	15
		T118	104	94	7	6	0	0	0	0	0	0	1	1	0	0	2	2	3	3
		T127	96	86	15	14	0	0	0	0	0	0	1	1	2	2	4	4	2	2
		T129	95	86	13	12	1	1	2	2	0	0	4	4	7	6	3	3	3	3
		T135	101	91	8	7	2	2	0	0	0	0	2	2	2	2	2	2	4	4
		T139	80	72	25	23	6	5	0	0	0	0	7	6	9	8	9	8	8	7
		T143	93	84	13	12	5	5	0	0	0	0	2	2	4	4	7	6	8	7
		T144	90	81	18	16	3	3	0	0	0	0	2	2	10	9	7	6	5	5
		T152	99	89	10	9	2	2	0	0	0	0	3	3	5	5	3	3	2	2
		T163	91	82	11	10	7	6	2	2	0	0	7	6	10	9	7	6	4	4
		T164	103	93	7	6	0	0	1	1	0	0	3	3	0	0	3	3	2	2
		T165	104	94	7	6	0	0	0	0	0	0	1	1	3	3	2	2	1	1
		T336	110		1		0		0		0		0		0		1		0	
		T340	110		0		1		0		0		0		0		1		0	
		T348	107		4		0		0		0		0		2		1		1	
		T350	109		2		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
ARIZONA	49	P015	48	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
		P062	48	98	1	2	0	0	0	0	0	0	0	0	0	0	1	2	0	0
		P073	45	92	4	8	0	0	0	0	0	0	3	6	0	0	1	2	0	0
		P101	48	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
		P105	48	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
		P111	45	92	3	6	1	2	0	0	0	0	1	2	1	2	0	0	3	6
		P112	34	69	11	22	4	8	0	0	0	0	7	14	7	14	1	2	4	8
		P134	48	98	1	2	0	0	0	0	0	0	1	2	0	0	0	0	0	0
		P135	45	92	4	8	0	0	0	0	0	0	1	2	2	4	0	0	1	2
		P136	25	51	16	33	6	12	1	2	1	2	10	20	16	33	7	14	2	4
		P173	44	90	5	10	0	0	0	0	0	0	2	4	1	2	0	0	2	4
		P175	37	76	9	18	3	6	0	0	0	0	9	18	4	8	0	0	2	4
		P176	33	67	10	20	6	12	0	0	0	0	9	18	7	14	2	4	4	8
		P177	48	98	1	2	0	0	0	0	0	0	0	0	1	2	0	0	0	0
		P178	40	82	9	18	0	0	0	0	0	0	2	4	5	10	2	4	0	0
		P180	30	61	15	31	2	4	2	4	0	0	8	16	12	24	3	6	1	2
		P186	27	55	18	37	4	8	0	0	0	0	9	18	8	16	4	8	5	10
		P189	47	96	2	4	0	0	0	0	0	0	2	4	0	0	0	0	0	0
		P190	27	55	16	33	5	10	1	2	0	0	11	22	12	24	2	4	3	6
		P191	41	84	8	16	0	0	0	0	0	0	4	8	2	4	1	2	1	2

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
CALIFORNIA	1165	F015	1057	91	94	8	13	1	1	0	0	0	21	2	33	3	35	3	27	2
		F062	1124	96	39	3	2	0	0	0	0	0	5	0	14	1	9	1	11	1
		F070	1143	98	21	2	1	0	0	0	0	0	3	0	6	1	7	1	6	1
		F071	1132	97	31	3	2	0	0	0	0	0	6	1	7	1	8	1	9	1
		F073	1067	92	86	7	11	1	1	0	0	0	24	2	34	3	26	2	21	2
		F101	1161	100	3	0	1	0	0	0	0	0	0	0	1	0	2	0	1	0
		F105	1128	97	37	3	0	0	0	0	0	0	2	0	8	1	13	1	10	1
		F111	981	84	158	14	22	2	4	0	0	0	36	3	55	5	51	4	42	4
		F112	856	73	249	21	50	4	10	1	0	0	77	7	92	8	98	8	80	7
		F123	1036	89	105	9	22	2	2	0	0	0	22	2	41	4	39	3	37	3
		F134	809	69	261	22	76	7	14	1	5	0	81	7	115	10	118	10	127	11
		F135	774	66	276	24	93	8	17	1	5	0	102	9	126	11	124	11	128	11
		F136	111	10	229	20	286	25	288	25	251	22	568	49	703	60	645	55	533	46
		F173	852	73	244	21	54	5	13	1	2	0	42	4	65	6	114	10	131	11
		F175	486	42	418	36	196	17	56	5	9	1	201	17	259	22	257	22	203	17
		F176	456	39	395	34	208	18	85	7	21	2	164	14	212	18	313	27	315	27
		F177	953	82	170	15	35	3	6	1	1	0	48	4	71	6	63	5	58	5
		F178	538	46	399	34	164	14	54	5	10	1	217	19	248	21	224	19	168	14
		F180	511	44	381	33	187	16	71	6	15	1	201	17	279	24	253	22	213	18
		F181	1085	93	77	7	3	0	0	0	0	0	16	1	23	2	19	2	19	2
		F182	1125	97	40	3	0	0	0	0	0	0	9	1	7	1	6	1	9	1
		F186	768	66	309	27	78	7	9	1	1	0	87	7	107	9	132	11	110	9
		F189	1013	87	126	11	23	2	3	0	0	0	20	2	36	3	54	5	56	5
		F190	423	36	412	35	233	20	80	7	17	1	188	16	250	21	297	25	307	26
		F191	1073	92	84	7	8	1	0	0	0	0	16	1	20	2	27	2	23	2
		F609	1164		1		0		0		0		1		0		0		0	
		F650	1162		3		0		0		0		0		2		1		0	
	89	T094	81	92	7	8	0	0	0	0	0	0	0	0	1	1	5	6	0	0
		T095	72	82	13	15	1	1	2	2	0	0	5	6	3	3	5	6	5	6
		T103	70	80	15	17	2	2	1	1	0	0	2	2	6	7	6	7	5	6
		T105	78	89	7	8	3	3	0	0	0	0	1	1	3	3	5	6	3	3
		T117	48	55	22	25	14	16	4	5	0	0	6	7	16	18	18	20	15	17
		T118	81	92	7	8	0	0	0	0	0	0	1	1	0	0	2	2	3	3
		T127	81	92	7	8	0	0	0	0	0	0	1	1	0	0	1	1	1	1
		T129	76	86	9	10	1	1	2	2	0	0	3	3	6	7	3	3	3	3
		T135	78	89	8	9	2	2	0	0	0	0	2	2	2	2	2	2	4	5
		T139	64	73	19	22	5	6	0	0	0	0	7	8	7	8	5	6	7	8
		T143	77	88	8	9	3	3	0	0	0	0	2	2	1	1	4	5	5	6
		T144	77	88	10	11	1	1	0	0	0	0	1	1	7	8	2	2	2	2
		T152	76	86	10	11	2	2	0	0	0	0	3	3	5	6	3	3	2	2
		T163	76	86	10	11	2	2	0	0	0	0	4	5	5	6	2	2	1	1
		T164	80	91	7	8	0	0	1	1	0	0	3	3	0	0	3	3	2	2
		T165	85	97	3	3	0	0	0	0	0	0	0	0	1	1	2	2	0	0
		T348	87		1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
HAWAII	27	F073	25	93	1	4	1	4	0	0	0	0	1	4	1	4	0	0	1	4
		F135	26	96	1	4	0	0	0	0	0	0	0	0	0	0	1	4	0	0
		F136	26	96	1	4	0	0	0	0	0	0	0	0	1	4	0	0	0	0
		F175	25	93	2	7	0	0	0	0	0	0	2	7	0	0	0	0	0	0
		F176	24	89	2	7	0	0	1	4	0	0	1	4	1	4	2	7	1	4
		F180	26	96	1	4	0	0	0	0	0	0	0	0	0	0	1	4	0	0
		F186	13	48	10	37	3	11	1	4	0	0	8	30	4	15	3	11	4	15
		F190	20	74	7	26	0	0	0	0	0	0	4	15	2	7	1	4	0	0
	17	T094	14	82	2	12	1	6	0	0	0	0	0	0	1	6	2	12	0	0
		T103	14	82	2	12	1	6	0	0	0	0	0	0	0	0	1	6	2	12
		T105	15	88	1	6	0	0	1	6	0	0	1	6	1	6	1	6	0	0
		T117	15	88	1	6	1	6	0	0	0	0	0	0	1	6	1	6	0	0
		T127	12	71	5	29	0	0	0	0	0	0	0	0	2	12	2	12	0	0
		T129	14	82	3	18	0	0	0	0	0	0	1	6	1	6	0	0	0	0
		T139	12	71	4	24	1	6	0	0	0	0	0	0	1	6	3	18	1	6
		T143	13	76	2	12	2	12	0	0	0	0	0	0	2	12	2	12	2	12
		T144	11	65	4	24	2	12	0	0	0	0	1	6	2	12	3	18	2	12
		T163	12	71	1	6	4	24	0	0	0	0	1	6	2	12	4	24	2	12
		T336	16		1		0		0		0		0		0		1		0	
		T348	14		3		0		0		0		0		2		1		0	
		T350	16		1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
NEVADA	26	F015	11	42	15	58	0	0	0	0	0	0	1	4	2	8	8	31	3	12
		F062	24	92	2	8	0	0	0	0	0	0	1	4	0	0	1	4	0	0
		F071	24	92	2	8	0	0	0	0	0	0	1	4	0	0	1	4	0	0
		F073	3	12	9	35	9	35	4	15	1	4	11	42	12	46	9	35	8	31
		F111	19	73	6	23	1	4	0	0	0	0	2	8	1	4	1	4	4	15
		F112	16	62	5	19	4	15	1	4	0	0	8	31	4	15	0	0	3	12
		F123	25	96	1	4	0	0	0	0	0	0	1	4	0	0	0	0	0	0
		F134	18	69	7	27	1	4	0	0	0	0	3	12	1	4	4	15	1	4
		F135	17	65	8	31	1	4	0	0	0	0	4	15	1	4	4	15	1	4
		F136	0	0	2	8	8	31	10	38	6	23	20	77	22	85	22	85	6	23
		F173	9	35	10	38	7	27	0	0	0	0	9	35	8	31	6	23	1	4
		F175	5	19	12	46	8	31	0	0	1	4	17	65	9	35	4	15	1	4
		F176	3	12	8	31	9	35	5	19	1	4	16	62	13	50	10	38	6	23
		F177	18	69	7	27	1	4	0	0	0	0	4	15	3	12	2	8	0	0
		F178	11	42	11	42	4	15	0	0	0	0	10	38	7	27	1	4	1	4
		F180	5	19	13	50	8	31	0	0	0	0	14	54	8	31	5	19	1	4
		F181	18	69	8	31	0	0	0	0	0	0	6	23	0	0	2	8	0	0
		F182	20	77	4	15	2	8	0	0	0	0	4	15	1	4	1	4	2	8
		F186	1	4	1	4	8	31	8	31	8	31	16	62	23	88	20	77	13	50
		F189	16	62	6	23	4	15	0	0	0	0	3	12	2	8	5	19	3	12
		F190	0	0	2	8	7	27	6	23	11	42	19	73	23	88	21	81	13	50
		F191	13	50	10	38	3	12	0	0	0	0	0	0	6	23	4	15	4	15
		F609	25		1		0		0		0		1		0		0		0	
		F636	25		1		0		0		0		1		0		0		0	
		F640	19		7		0		0		0		7		0		0		0	
		F648	20		6		0		0		0		6		0		0		0	
		F650	19		7		0		0		0		7		0		0		0	
	6	T094	5	83	1	17	0	0	0	0	0	0	0	0	1	17	0	0	0	0
		T095	3	50	1	17	2	33	0	0	0	0	0	0	1	17	1	17	2	33
		T103	4	67	1	17	1	17	0	0	0	0	0	0	1	17	0	0	2	33
		T105	4	67	1	17	1	17	0	0	0	0	1	17	1	17	0	0	1	17
		T117	2	33	0	0	3	50	1	17	0	0	0	0	2	33	3	50	2	33
		T127	3	50	3	50	0	0	0	0	0	0	0	0	0	0	1	17	1	17
		T129	5	83	1	17	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T139	4	67	2	33	0	0	0	0	0	0	0	0	1	17	1	17	0	0
		T143	3	50	3	50	0	0	0	0	0	0	0	0	1	17	1	17	1	17
		T144	2	33	4	67	0	0	0	0	0	0	0	0	1	17	2	33	1	17
		T163	3	50	0	0	1	17	2	33	0	0	2	33	3	50	1	17	1	17
		T165	2	33	4	67	0	0	0	0	0	0	1	17	2	33	0	0	1	17
		T340	5		0		1		0		0		0		0		1		0	
		T350	5		1		0		0		0		0		0		0		0	

```
STATE          FACIL CODE NONE   %    ONE   %    TWO   % THREE   %  FOUR   %     1985   %  1984   %  1983   %  1982   %
-------------------------------------------------------------------------------    ---------------------------------------
GUAM               1 F173    0   0      1 100      0   0     0   0     0   0        0   0     0   0     0   0     0   0
                     F175    0   0      1 100      0   0     0   0     0   0        0   0     0   0     0   0     0   0
                     F176    0   0      1 100      0   0     0   0     0   0        0   0     0   0     0   0     0   0
```

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
REGION 10	380	P015	366	96	14	4	0	0	0	0	0	0	2	1	2	1	5	1	2	1
		P062	372	98	8	2	0	0	0	0	0	0	4	1	1	0	1	0	1	0
		P070	363	96	15	4	2	1	0	0	0	0	7	2	4	1	5	1	1	0
		P071	371	98	9	2	0	0	0	0	0	0	0	0	2	1	2	1	4	1
		P073	316	83	56	15	7	2	1	0	0	0	23	6	25	7	12	3	2	1
		P101	377	99	3	1	0	0	0	0	0	0	1	0	1	0	0	0	0	0
		P105	372	98	8	2	0	0	0	0	0	0	0	0	2	1	3	1	3	1
		P111	296	78	68	18	14	4	2	1	0	0	23	6	25	7	24	6	9	2
		P112	279	73	79	21	16	4	5	1	1	0	21	6	35	9	34	9	15	4
		P123	355	93	24	6	1	0	0	0	0	0	8	2	7	2	7	2	1	0
		P134	282	74	79	21	17	4	2	1	0	0	29	8	40	11	28	7	9	2
		P135	210	55	94	25	50	13	20	5	6	2	65	17	87	23	57	15	44	12
		P136	85	22	74	19	80	21	90	24	51	13	151	40	211	56	141	37	83	22
		P173	316	83	58	15	5	1	1	0	0	0	18	5	22	6	17	4	5	1
		P175	161	42	113	30	78	21	23	6	5	1	93	24	112	29	73	19	40	11
		P176	153	40	139	37	64	17	21	6	3	1	77	20	96	25	78	21	31	8
		P177	344	91	36	9	0	0	0	0	0	0	9	2	9	2	13	3	2	1
		P178	255	67	96	25	25	7	4	1	0	0	43	11	60	16	30	8	10	3
		P180	201	53	110	29	50	13	15	4	4	1	48	13	95	25	59	16	27	7
		P181	365	96	13	3	2	1	0	0	0	0	5	1	5	1	9	1	1	0
		P182	367	97	12	3	1	0	0	0	0	0	6	2	2	1	1	0	0	0
		P186	195	51	121	32	53	14	11	3	0	0	52	14	83	22	63	17	28	7
		P189	357	94	22	6	1	0	0	0	0	0	7	2	6	2	5	1	3	1
		P190	167	44	133	35	60	16	18	5	2	1	80	21	86	23	59	16	28	7
		P191	335	88	41	11	3	1	1	0	0	0	4	1	12	3	15	4	8	2
		P636	367		13		0		0		0		10		3		0		0	
		P640	372		8		0		0		0		3		4		1		0	
		P648	366		13		1		0		0		8		6		1		0	
		P650	366		14		0		0		0		9		4		1		0	
	151	T094	91	60	40	26	16	11	4	3	0	0	3	2	30	20	22	15	7	5
		T095	87	58	44	29	14	9	5	3	1	1	1	1	30	20	22	15	12	8
		T103	75	50	55	36	17	11	4	3	0	0	7	5	40	26	20	13	8	5
		T105	67	44	53	35	27	18	4	3	0	0	9	6	42	28	24	16	16	11
		T117	25	17	56	37	45	30	19	13	6	4	12	8	84	56	58	38	23	15
		T118	147	97	4	3	0	0	0	0	0	0	0	0	4	3	0	0	0	0
		T127	128	85	21	14	2	1	0	0	0	0	0	0	11	7	4	3	3	2
		T129	111	74	27	18	12	8	1	1	0	0	1	1	20	13	18	12	3	2
		T135	134	89	14	9	3	2	0	0	0	0	1	1	10	7	4	3	2	1
		T139	51	34	51	34	41	27	8	5	0	0	10	7	46	30	42	28	14	9
		T143	71	47	54	36	18	12	6	4	2	1	4	3	36	24	19	13	10	7
		T144	77	51	51	34	15	10	7	5	1	1	5	3	31	21	17	11	16	11
		T152	121	80	27	18	2	1	1	1	0	0	0	0	15	10	6	4	8	5
		T163	120	79	28	19	3	2	0	0	0	0	0	0	14	9	4	3	2	1
		T164	142	94	9	6	0	0	0	0	0	0	0	0	2	1	1	1	2	1
		T165	120	79	22	15	6	4	3	2	0	0	3	2	16	11	10	7	7	5
		T169	150	99	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T336	150		1		0		0		0		0		0		1		0	
		T340	150		1		0		0		0		0		0		0		1	
		T348	150		1		0		0		0		0		1		0		0	
		T350	150		1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
ALASKA	9	F070	8	89	1	11	0	0	0	0	0	0	0	0	0	0	1	11	0	0
		F073	7	78	1	11	1	11	0	0	0	0	0	0	0	0	2	22	0	0
		F111	7	78	2	22	0	0	0	0	0	0	1	11	0	0	0	0	1	11
		F112	7	78	1	11	1	11	0	0	0	0	0	0	0	0	1	11	1	11
		F134	6	67	2	22	1	11	0	0	0	0	0	0	1	11	3	33	0	0
		F135	4	44	4	44	1	11	0	0	0	0	1	11	2	22	3	33	0	0
		F136	4	44	2	22	3	33	0	0	0	0	2	22	1	11	4	44	1	11
		F173	5	56	2	22	1	11	1	11	0	0	0	0	2	22	4	44	1	11
		F175	4	44	3	33	0	0	2	22	0	0	0	0	3	33	4	44	1	11
		F176	0	0	5	56	2	22	2	22	0	0	1	11	5	56	6	67	2	22
		F178	7	78	0	0	2	22	0	0	0	0	1	11	1	11	2	22	0	0
		F180	6	67	3	33	0	0	0	0	0	0	0	0	0	0	3	33	0	0
		F181	8	89	1	11	0	0	0	0	0	0	0	0	0	0	1	11	0	0
		F186	8	89	1	11	0	0	0	0	0	0	0	0	0	0	1	11	0	0
		F190	4	44	5	56	0	0	0	0	0	0	2	22	0	0	0	0	0	0
		F191	8	89	1	11	0	0	0	0	0	0	1	11	0	0	0	0	0	0
		F640	8		1		0		0		0		0		1		0		0	
		F648	8		1		0		0		0		0		1		0		0	
		F650	8		1		0		0		0		0		1		0		0	
	3	T094	2	67	1	33	0	0	0	0	0	0	0	0	0	0	0	0	1	33
		T103	1	33	1	33	1	33	0	0	0	0	1	33	0	0	0	0	2	67
		T105	2	67	0	0	1	33	0	0	0	0	1	33	0	0	0	0	1	33
		T336	2		1		0		0		0		0		0		1		0	
		T340	2		1		0		0		0		0		0		0		1	
		T348	2		1		0		0		0		0		1		0		0	
		T350	2		1		0		0		0		0		0		0		1	

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
IDAHO	59	F015	57	97	2	3	0	0	0	0	0	0	0	0	0	0	0	0	1	2
		F073	54	92	5	8	0	0	0	0	0	0	1	2	3	5	1	2	0	0
		F105	57	97	2	3	0	0	0	0	0	0	0	0	0	0	0	0	2	3
		F111	41	69	12	20	5	8	1	2	0	0	4	7	4	7	8	14	3	5
		F112	44	75	10	17	3	5	1	2	1	2	6	10	5	8	5	8	2	3
		F123	58	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F134	53	90	6	10	0	0	0	0	0	0	2	3	1	2	0	0	0	0
		F135	46	78	12	20	1	2	0	0	0	0	3	5	1	2	3	5	1	2
		F136	35	59	15	25	8	14	1	2	0	0	11	19	10	17	9	15	1	2
		F173	47	80	11	19	1	2	0	0	0	0	6	10	2	3	1	2	1	2
		F175	42	71	14	24	2	3	1	2	0	0	9	15	3	5	5	8	1	2
		F176	28	47	18	31	11	19	2	3	0	0	13	22	6	10	9	15	1	2
		F177	55	93	4	7	0	0	0	0	0	0	2	3	1	2	0	0	0	0
		F178	46	78	12	20	1	2	0	0	0	0	6	10	2	3	2	3	0	0
		F180	46	78	13	22	0	0	0	0	0	0	4	7	3	5	1	2	2	3
		F181	57	97	2	3	0	0	0	0	0	0	1	2	0	0	0	0	1	2
		F182	58	98	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		F186	44	75	13	22	0	0	2	3	0	0	6	10	3	5	1	2	4	7
		F189	55	93	4	7	0	0	0	0	0	0	2	3	0	0	1	2	0	0
		F190	24	41	24	41	7	12	4	7	0	0	10	17	11	19	8	14	6	10
		F191	53	90	5	8	1	2	0	0	0	0	0	0	0	0	4	7	1	2
		F636	52		7		0		0		0		6		1		0		0	
		F640	57		2		0		0		0		1		1		0		0	
		F648	56		3		0		0		0		2		1		0		0	
		F650	52		7		0		0		0		6		1		0		0	
	4	T117	2	50	2	50	0	0	0	0	0	0	0	0	2	50	0	0	0	0
		T127	2	50	2	50	0	0	0	0	0	0	0	0	1	25	0	0	0	0
		T139	3	75	1	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T144	3	75	1	25	0	0	0	0	0	0	0	0	0	0	1	25	0	0
		T163	2	50	2	50	0	0	0	0	0	0	0	0	1	25	0	0	0	0

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
OREGON	67	F015	59	88	8	12	0	0	0	0	0	0	1	1	0	0	4	6	1	1
		F062	66	99	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0
		F073	56	84	11	16	0	0	0	0	0	0	7	10	2	3	0	0	0	0
		F101	64	96	3	4	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		F111	48	72	18	27	1	1	0	0	0	0	5	7	4	6	5	7	0	0
		F112	52	78	13	19	0	0	2	3	0	0	4	6	1	1	7	10	0	0
		F123	63	94	3	4	1	1	0	0	0	0	1	1	2	3	1	1	0	0
		F134	60	90	7	10	0	0	0	0	0	0	2	3	3	4	1	1	0	0
		F135	55	82	12	18	0	0	0	0	0	0	3	4	3	4	2	3	1	1
		F136	32	48	26	39	7	10	2	3	0	0	13	19	17	25	3	4	3	4
		F173	60	90	7	10	0	0	0	0	0	0	4	6	1	1	2	3	0	0
		F175	57	85	8	12	2	3	0	0	0	0	4	6	2	3	2	3	0	0
		F176	40	60	17	25	7	10	2	3	1	1	7	10	9	13	10	15	4	6
		F177	62	93	5	7	0	0	0	0	0	0	2	3	1	1	2	3	0	0
		F178	51	76	14	21	2	3	0	0	0	0	7	10	4	6	6	9	0	0
		F180	53	79	13	19	1	1	0	0	0	0	2	3	5	7	4	6	1	1
		F181	66	99	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0
		F182	66	99	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
		F186	44	66	18	27	5	7	0	0	0	0	2	3	6	9	6	9	4	6
		F189	65	97	2	3	0	0	0	0	0	0	1	1	1	1	0	0	0	0
		F190	40	60	20	30	7	10	0	0	0	0	5	7	12	18	4	6	3	4
		F191	60	90	7	10	0	0	0	0	0	0	1	1	3	4	2	3	0	0
		F636	61		6		0		0		0		4		2		0		0	
		F640	62		5		0		0		0		2		2		1		0	
		F648	57		9		1		0		0		6		4		1		0	
		F650	61		6		0		0		0		3		2		1		0	
	114	T094	59	52	37	32	14	12	4	4	0	0	1	1	28	25	22	19	5	4
		T095	58	51	39	34	12	11	4	4	1	1	1	1	24	21	18	16	11	10
		T103	47	41	47	41	16	14	4	4	0	0	5	4	38	33	19	17	6	5
		T105	50	44	44	39	18	16	2	2	0	0	3	3	32	28	19	17	9	8
		T117	12	11	41	36	38	33	17	15	6	5	6	5	76	67	51	45	18	16
		T118	110	96	4	4	0	0	0	0	0	0	0	0	4	4	0	0	0	0
		T127	95	83	17	15	2	2	0	0	0	0	0	0	10	9	4	4	2	2
		T129	74	65	27	24	12	11	1	1	0	0	1	1	20	18	18	16	3	3
		T135	98	86	13	11	3	3	0	0	0	0	1	1	9	8	4	4	2	2
		T139	30	26	42	37	36	32	6	5	0	0	7	6	40	35	39	34	9	8
		T143	47	41	44	39	17	15	5	4	1	1	2	2	30	26	16	14	9	8
		T144	53	46	41	36	13	11	6	5	1	1	3	3	24	21	13	11	14	12
		T152	88	77	23	20	2	2	1	1	0	0	0	0	13	11	5	4	8	7
		T163	92	81	20	18	2	2	0	0	0	0	0	0	12	11	4	4	2	2
		T164	106	93	8	7	0	0	0	0	0	0	0	0	2	2	1	1	2	2
		T165	91	80	15	13	6	5	2	2	0	0	0	0	15	13	9	8	6	5

STATE	FACIL	CODE	NONE	%	ONE	%	TWO	%	THREE	%	FOUR	%	1985	%	1984	%	1983	%	1982	%
WASHINGTON	245	F015	241	98	4	2	0	0	0	0	0	0	1	0	2	1	1	0	0	0
		F062	238	97	7	3	0	0	0	0	0	0	3	1	1	0	1	0	1	0
		F070	229	93	14	6	2	1	0	0	0	0	7	3	4	2	4	2	1	0
		F071	236	96	9	4	0	0	0	0	0	0	0	0	2	1	2	1	4	2
		F073	199	81	39	16	6	2	1	0	0	0	15	6	20	8	9	4	2	1
		F105	239	98	6	2	0	0	0	0	0	0	0	0	2	1	3	1	1	0
		F111	200	82	36	15	8	[illegible]	1	0	0	0	13	5	17	7	11	4	5	2
		F112	176	72	55	22	12	5	2	1	0	0	11	4	29	12	21	9	12	5
		F123	225	92	20	8	0	0	0	0	0	0	7	3	5	2	6	2	1	0
		F134	163	67	64	26	16	7	2	1	0	0	25	10	35	14	24	10	9	4
		F135	105	43	66	27	48	20	20	8	6	2	58	24	81	33	49	20	42	17
		F136	14	6	31	13	62	25	87	36	51	21	125	51	183	75	125	51	78	32
		F173	204	83	38	16	3	1	0	0	0	0	8	3	17	7	10	4	3	1
		F175	58	24	88	36	74	30	20	8	5	2	80	33	104	42	62	25	38	16
		F176	85	35	99	40	44	18	15	6	2	1	56	23	76	31	53	22	24	10
		F177	218	89	27	11	0	0	0	0	0	0	5	2	7	3	11	4	2	1
		F178	151	62	70	29	20	8	4	2	0	0	29	12	53	22	20	8	10	4
		F180	96	39	81	33	49	20	15	6	4	2	42	17	87	36	51	21	24	10
		F181	234	96	9	4	2	1	0	0	0	0	4	2	4	2	4	2	0	0
		F182	234	96	10	4	1	0	0	0	0	0	6	2	2	1	0	0	0	0
		F186	99	40	89	36	48	20	9	4	0	0	44	18	74	30	55	22	20	8
		F189	228	93	16	7	1	0	0	0	0	0	4	2	5	2	4	2	3	1
		F190	99	40	84	34	46	19	14	6	2	1	63	26	63	26	47	19	19	8
		F191	214	87	28	11	2	1	1	0	0	0	2	1	9	4	9	4	7	3
	30	T094	26	87	2	7	2	7	0	0	0	0	2	7	2	7	0	0	1	3
		T095	22	73	5	17	2	7	1	3	0	0	0	0	6	20	4	13	1	3
		T103	23	77	7	23	0	0	0	0	0	0	1	3	2	7	1	3	0	0
		T105	11	37	9	30	8	27	2	7	0	0	5	17	10	33	5	17	6	20
		T117	8	27	13	43	7	23	2	7	0	0	6	20	6	20	7	23	5	17
		T127	28	93	2	7	0	0	0	0	0	0	0	0	0	0	0	0	1	3
		T135	29	97	1	3	0	0	0	0	0	0	0	0	1	3	0	0	0	0
		T139	15	50	8	27	5	17	2	7	0	0	3	10	6	20	3	10	5	17
		T143	17	57	10	33	1	3	1	3	1	3	2	7	6	20	3	10	1	3
		T144	18	60	9	30	2	7	1	3	0	0	2	7	7	23	3	10	2	7
		T152	26	87	4	13	0	0	0	0	0	0	0	0	2	7	1	3	0	0
		T163	23	77	6	20	1	3	0	0	0	0	0	0	1	3	0	0	0	0
		T164	29	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		T165	22	73	7	23	0	0	1	3	0	0	3	10	1	3	1	3	1	3
		T169	29	97	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[COMMITTEE STAFF NOTE: The following newspaper articles were submitted for the record by Senator Bradley of New Jersey.]

THE SUNDAY RECORD, SEPTEMBER 29, 1985, A-1

Cracking down on bad operators

NURSING-HOME NEGLECT
The Search for Solutions
Part 1: NATIONAL NIGHTMARE

There are more than 2,000 substandard nursing homes — homes where horror stories are commonplace. It's a national nightmare of neglect.

EDITOR'S NOTE: In March, The Record published "Nightmare of Neglect," a series that described mistreatment of workers and patients at two North Jersey nursing homes — the Bel Air Manors in Wanaque and Oakland. The homes' operations are now the subject of state and federal investigations. This follow-up series examines nursing-home practices around the nation and efforts at reform.

By Gale Scott
and Bruce Locklin
Staff Writers

WASHINGTON, D.C. — There is a hard core of bad nursing homes where the elderly live without dignity, where many are neglected — sometimes neglected to death.

A Kearny grandmother named Helen DeFalco starved to death in a New Jersey nursing home, because the staff was too busy to feed her.

In Washington, an 86-year-old woman froze to death in her overturned wheelchair outside a nursing home after no one noticed she was missing.

In a Houston nursing home, a retired oil worker's bedsores became grossly infected, causing gangrene and death.

Experts estimate that about 10 percent of the country's 23,000 nursing homes are substandard. That means there are more than 2,000 homes where horror stories are commonplace. It's a national nightmare of neglect.

The responsibility for ending the nightmare has been left to state governments. Several are leading in the search for solutions:

- California has instituted severe punishments for nursing homes that neglect their patients — last month one home was fined $230,000. "The nursing homes don't like us much, but it's working," said a licensing official.

- Illinois has enticed homes into improving care by offering extra money and achievement certificates for providing better care. The program has a double whammy in that it also calls for installing a state nurse-inspector in every home that participates, giving the state firsthand information on conditions.

- Maryland is paying homes more for taking in sicker patients. It has not worked perfectly, because at least one home took in those patients without providing the extra care they needed. But state health officials like the program because there is no more backlog of severely ill patients waiting for beds.

- Texas has cut through red tape and punished repeat offenders by immediately withholding Medicaid payments to homes found to have severe violations of health standards.

- New York has tapped federal funds to investigate patient neglect. The funds are available to all states to investigate bad nurs-

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Improving deficient nursing homes

FROM PAGE A-1

ing homes, but most use them just to look for Medicaid fraud.

- Delaware and Texas recently began permitting people to sue for their own pain and suffering because of the wrongful death of a family member. In Texas, that has led to multimillion-dollar claims for nursing-home deaths. Some reformers believe that will frighten nursing homes into giving better care.

It is too early to measure the effectiveness of some of these systems, because they have not been in operation long enough to check results. Some experts believe that there is no cure-all for nursing-home neglect. That's because there are too many unscrupulous operators, more interested in profits than patients, whose full-time goal is beating the system.

One of the nation's leading experts on nursing homes, Bruce Vladeck, says that does not mean reformers should give up.

"If I were running a regulatory agency, the first thing I would do is not do any one thing for too long," Vladeck said. "I'd want to keep changing the rules on those guys. Any system gets beat after a while. What you want to do is stay one step ahead of them."

Why are there so many bad nursing homes?

Mainly because government policy has developed haphazardly for 50 years. The federal government turned over much of the responsibility for building and running nursing homes to private entrepreneurs. But it failed to build in effective checks to prevent bad or inept operators from neglecting patients.

In classical economic theory, the marketplace works to drive customers away from badly run businesses. But that does not work with nursing homes: first, because there are not enough beds to go around; second, because the government keeps pumping money into deficient homes; and third, because even in states with enough beds, nursing-home patients are often too frail to shop around.

Staff photo by Al Paglione

Bruce Vladek, author and expert on nursing homes.

The federal government began financing the nursing-home boom in the 1950's with insured loans. Through Medicaid, enacted in 1966, government eventually became the prime buyer of nursing-home services, now paying more than half the total annual bill. Federal policies in the 1950's and 1960's made nursing homes attractive to fast-buck artists, what Vladeck calls "a hard core of shady operators."

While paying the bill for nursing-home care, federal authorities almost totally abdicated responsibility for quality, passing to the states the job of inspecting and enforcing.

Health departments across the country have proved to be inept at dealing with corrupt nursing-home operators. Inspectors usually end up becoming consultants rather than cops, trying to coax operators into compliance. The bad nursing-home operators tend to go unpunished unless they leave a paper trail of fraud.

Even marginally satisfactory homes, where greed isn't management's prime motivation, can become dangerously deficient overnight because of unexpected staff shortages. Patients who need total care deteriorate quickly if neglected.

Since the mid-1960's, each new nursing home scandal has brought new demands for reform. But the outrages continue. Veteran reform advocates such as Robert Brown, a Detroit law school professor, say the public has a limited attention span on nursing-home horrors.

But Brown and other experts believe that for the first time since New York's Bernard Bergman scandal in the early 1970's, pressures are building for significant national changes. (Bergman, who died last year at 73, was an Orthodox rabbi and head of a $25-million nursing-home empire. Disclosures about his operations led to federal and state prison terms for fraud.)

"It seems to me we might be at a point where we're ready for the second round," Brown said. "We had the Bergman round of reform. Maybe now we are ready for more."

TOMORROW: Deaths in a Texas nursing home cause indictments for murder.

Researcher Barbara Gardner contributed to this report.

A sampler of horror stories from around the country

Across the nation, there are nursing-home horrors. These are some that surfaced recently.

● **WASHINGTON, D.C.** — The D.C. Village Nursing Home is 500-bed, city-run home in the southwest corner of the District of Columbia. In January, police found 86-year-old Wilhelmina Franklin frozen to death outside the home in her overturned wheelchair. Miss Franklin was said to have died because the harried staff did not notice she was missing. At the same home in April, George Austin Spells, 71, was scalded to death in a bathtub. City inspection records showed that the home had been cited four years earlier for failure to install valves that would have prevented such injuries. "D.C. Village has been deplorable for decades," said Michael Schuster, a lawyer for a Washington-based advocacy group for the elderly. "We have about two or three other problem homes out of about 16 nursing homes in D.C. We have been trying for years to do something about the situation."

● **HOUSTON** — Blalock Nursing Home North, as it was called before it was renamed this year, is a small ranch-style nursing home crammed between a sooty freeway and a grimy truck-rental garage about 10 miles northwest of the downtown's glittering skyscrapers. Last year, Joseph Valley Sr., a handsome, proud, family man retired from the Shell Oil Company, died a horrible death from gangrene resulting from grossly infected bedsores. His widow, Selenia Valley, has sued the home and its parent corporation, ARA Services Corporation of Philadelphia, for wrongful death. So have eight other families. They charge that their relatives at Blalock North and five other ARA-owned homes in Houston died because of neglect. Damages sought are in the tens of millions of dollars for each case. After the suits were filed, the state attorney-general's office began investigating the charges. Much criticism has focused on the state health department. That department's response has been that it did the best it could with existing laws and limited resources.

● **BALTIMORE** — In October of 1984, a man from the Pall Mall Nursing Home in the Pimlico section of the city was taken to a hospital, where he lost a leg because of infected bedsores. The incident was particularly disturbing to Medicaid officials. It happened as a result of an intended improvement. Maryland has begun paying nursing homes extra to take patients needing extra care. Pall Mall allegedly took the patients in to get the money but was not equipped to deliver the services. "The man lost his leg because the nursing home staff didn't know how to care for him," said Maryland Medicaid's James Millstone.

● **SAN FRANCISCO** — A group called Bay Area Advocates for Nursing Home Reform worked hard to help get a package of changes enacted by the California legislature earlier this year. The emphasis was on stiff penalties for poor care. But Pat McGinness, the advocacy group's spokeswoman, says it is too soon to tell whether the changes will work. She thinks the results so far have been disappointing. For one thing, a state health department official was fired after he was tape-recorded advising nursing home administrators on how to get around the new regulations. For another, said Ms. McGinness, the group is finding continuing evidence of poor care. Following up on a recent telephone tip concerning widespread bedsores in an Oakland home, the group checked and found a 57-pound woman patient, covered with bedsores, who had not been treated by a doctor.

Joseph Valley
Died of infected bedsores

● **CHICAGO** — Reformers are optimistic about a state program that rewards nursing homes when they give better care. But the state's worst homes, mostly in Chicago, are too far gone to participate. "We've closed two down this year, and we may close more," said Connie Cheren, a state Medicaid official.

● **OAKDALE, Calif.** — A 75-year-old patient at the Oakdale Convalescent Hospital died in July after being tied into his bed in such a way that when the head of the bed was raised, the man was asphyxiated by the restraints. Health officials ruled the man should have been sedated instead of being tied down and fined the home $55,000. "Normally it would be a $10,000 fine, but this was a repeat violation of the same regulation," said a health department spokesman.

● **MIAMI** — Commissioned to do a study of Florida's long-term care facilities two years ago, researcher Steve Biondi concluded that 36 percent of the state's nursing homes were substandard. In the Miama area, he found that at least half the homes were below minimum standards.

● **NEW YORK** — Having a reputation as being the toughest state for nursing home enforcement did not save state Medicaid officials from concern and embarrassment this year after stories about the Greater Harlem Nursing Home on West 138th Street hit the papers. Political connections allegedly helped keep the home open after state inspectors found medical neglect, filthy conditions, and dangerously sloppy nursing practices.

● **SACRAMENTO** — After new regulations passed this spring made it easier to crack down on bad nursing home care, state health officials started in the capital city. Sacramento's Countryside Convalescent Hospital was fined $135,000 in June for violations alleged to have killed two patients. In August, the home's license was revoked.

PASSAIC
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The Record

NORTHERN NEW JERSEY

Redefining murder

Health care on trial

By Gale Scott
Staff Writer

GALVESTON, Tex. — Executives at Autumn Hills Convalescent Centers Inc. are charged with murdering two women — not with poison or a gun, but by failing to give them basic care in a Texas City nursing home.'

NURSING-HOME NEGLECT The Search for Solutions

Part 2: PUNISHMENTS

The home allegedly neglected to feed, bathe, turn, and change Edna May Witt, 78, and Elnora Breed, 87. A grand juror on the panel that returned the murder indictments told a reporter that Autumn Hills "basically just let Edna lay there and die."

Texas wants to put the fear of God into nursing-home owners. It has turned to its courts, hoping a murder conviction will frighten the industry into compliance — scare them straight.

"We hope it will have a positive effect on nursing-home care," said David Marks, prosecutor in the case, who was scheduled to make his opening statement to the jury today. But Marks would rather fix the system:

"Obviously this case would not have ended up in the criminal justice system, had the state inspection process been working as it should have," he said.

California may have found a better way: A reform package adopted in March gives health officials drastic remedies to use against bad homes, including six-figure fines that are the highest in the nation.

The stiff fine system already has driven one bad home out of business. The owner, learning he faced more than $100,000 in fines, surrendered his license, sold his home, and promised not to open another for at least three years.

COLLEGE PARK
CARE CENTER
HOME HEALTH
AGENCY

Staff photo by Gale Scott

The former Autumn Hills Convalescent Center in Texas City, Tex.

The California approach is being watched by reformers in Washington, where the Institute of Medicine is winding up a study on nursing-home reform.

One policy analyst concluded that regulatory changes will work only when two conditions result:

- Bad nursing-home operators become convinced that government has a good chance of catching them.
- Punishments are sufficient to make sure no one wants to get caught.

Other reformers believe the best way to

See PENALIZING, Page B-21

States vary widely in their efforts

Penalizing bad nursing homes

FROM PAGE A-1

get nursing homes to give good care is to reward them. Experiments mixing enticements and threats, carrots and sticks, are going on around the nation.

Tomorrow's report will examine the carrots. Here's a rundown on the sticks:

FINES. A violation that results in a patient's death can cost a California nursing home a six-figure fine. That same offense in Maryland costs nothing, for there are no fines. More states are like California than Maryland, but there is a wide range of monetary penalties.

The trend toward increasing them is growing, according to Sandra Johnson, a St. Louis law professor who studied the states' fining systems for the Institute of Medicine.

Nearly all states that collect fines tailor the severity of the fine to the seriousness of the offense. They set categories of violations, usually A, B, C, and D. The fine usually goes from $50 for a D violation to several thousand for an A violation. New Jersey, which has a maximum fine of $250 a day, is considering adopting such a structure.

California can fine a home $25,000 for a violation that has cost a patient's life, as it did in San Francisco last month, when an 82-year-old patient died after being raped in her bed by an unknown assailant. The case is being investigated by police, but meanwhile the home has been cited and fined for improper supervision of patients.

If an inspector returns and sees that a violation has not been corrected, the fine can be tripled.

The biggest fine to date was handed out in late August in Los Gatos, Calif. Beverly Manor Convalescent Hospital was fined $212,000 for violations linked to the deaths of two patients.

Another Beverly-owned home in Oakdale was fined $55,000 in early August after it was accused of tying a 71-year-old patient to his bed in such a way that he was asphyxiated by the restraints.

Media advisories announcing fines and citations are flowing steadily from the health department.

"The nursing homes don't like us much, but we think it's working," said Gil Wilmer, assistant chief of field operations for the California health department's licensing division.

The fines may be appealed, though California hopes to collect at least half the money through a new law that allows homes to get a 50-percent reduction in fines in exchange for not going to court.

Ms. Johnson, who studied how states collect penalty money, said fines don't work in all cases.

"You can't use fines to get a bad place to change. By that time, either from skimming or bad management, they usually just don't have the money to run the place right," she said.

Ms. Johnson believes fines are more effective for mediocre to good homes. "It's a form of behavior modification. You may have to fine them again, but it usually won't be for the same thing twice."

REVOKING LICENSES. All states have the option of closing down a bad home by taking away its license. Revocation doesn't require criminal charges such as those raised in Autumn Hills. Repeated serious violations, such as chronic short staffing and food complaints, can be enough.

New Jersey is ahead of the nation in the use of its receivership law, which permits the state to take over a bad nursing home so that the patients do not have to be moved. Other states are being urged to copy New Jersey's law.

But revoking licenses isn't easy for state health departments, because it means building a court case, and health inspectors usually aren't experts in gathering evidence. Among the reforms California adopted was a measure calling for better training of investigators, a measure many reformers advocate.

"The surveyor who signs the survey for licensing probably has not been trained in any type of court procedure," said the Institute of Medicine's Bob Burke. "Then she is turned over to a state attorney, who is most likely also a kid right out of law school. Then they wonder why they aren't having any luck with the courts."

Wisconsin has built some successful cases by training inspectors and teaming them quickly with lawyers. When a Wisconsin inspector detects a life-threatening situation, the inspector phones a state attorney and, while still at the nursing home, gets advice on how to proceed.

RECEIVERSHIPS. New Jersey is ahead of the nation in the use of its receivership law, which permits the state to take over a bad nursing home or to get a judge to appoint someone to run the home so the patients do not have to be moved. Other states are being urged to copy New Jersey's law.

Two of Governor Kean's cabinet members have proposed a further strengthening of New Jersey's law. The commissioners of health and human services want the state to be able to force the owner to sell the home, rather than let him take over once the receiver gets the place into shape.

New Jersey's nursing-home industry opposes that amendment.

In California, receivership has been on the books for several years but has never been used, said Gil Wilmer, a health department administrator.

Wilmer said California has had problems finding receivers. His department recently closed a Sacramento home and relocated patients because the state couldn't find a receiver near enough the home to run it. "We like the receivership law and we are going to try and make better use of it, but for us it's been a problem of geography," said Wilmer.

● WITHHOLDING PAYMENTS. Texas doesn't use fines. Instead it immediately holds back state and federal Medicaid payments to homes found seriously deficient. Called "vendor hold," it's another sanction being considered in New Jersey, which paid nursing homes to care for 20,000 Medicaid patients last year.

The Texas system allows a home to collect the withheld funds if corrections are made. But a home put on vendor hold twice in one year loses the money and its Medicaid contract.

"We call it two strikes and you're out," said Janice Caldwell, a human services official who initiated the system when she came to Texas from Washington three years ago.

Vendor hold netted $4.2 million for Texas last year, Ms. Caldwell said. A former federal Health Care Finance Agency official, Ms. Caldwell said the practice has improved what she concedes has been a poor statewide record for nursing-home enforcement.

There are two reasons the Texas system, if transplanted to New Jersey, would be even harsher on nursing homes. First, more money per patient is involved. Medicaid payments are higher in New Jersey because nursing home costs are higher. (The cost of a bed in Texas is about $40 a day, compared with about $80 in New Jersey.)

Also, in New Jersey, loss of Medicaid money would be likely to have a more immediate impact. That is because, unlike Texas, New Jersey has few chain-owned nursing homes. The chains dominate Texas's nursing-home industry, sometimes thwarting efforts at reform by their ability to absorb big losses of Medicaid money and to shift personnel to homes where there are problems. New Jersey homes would be less likely to do that.

● INTERMEDIATE SANCTIONS. Social scientists studying nursing-home care say states need a full arsenal of mid-range weapons to deal with bad nursing homes. They call them "intermediate sanctions," which they define as any punishment short of closing the place.

Sanctions are being used in permutations so varied that it has taken researchers at Washington's Institute of Medicine three years to sort them out.

"What we have concluded is that we have 50 states and 50 completely different nursing-home monitoring systems," said the institute's Bob Burke. "The interesting thing we found is that if you have more than five sanctions on the books, you are likely to use them. If you have one or two, you probably won't use any," said Burke.

Officials, nursing-home professionals, and reformers agree that it takes a combination of changes to get solid reform. Swift, effective punishment for neglect and abuse is one tool, and California thinks it has become a model for the nation in using it.

"We are light years ahead of the country," said Richard Mahan, a good-government advocate who worked for years to get the California package into law. "But a lot more has to be done. We still have to look at the whole issue of quality of care and how you create incentives or a way to get away from just assuming that if you are placed in a nursing home, you are there to die."

TOMORROW: Rewards for good care — how the profit motive is being used to improve nursing homes.

Bruce Locklin and Barbara Gardner contributed to this report.

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THE RECORD, TUESDAY, OCTOBER 1, 1985

Cash incentives for quality care

By Gale Scott
Staff Writer

Fish tanks are in short supply in certain parts of Illinois, because of nursing-home reforms.

Since June 1, approximately 660 of the state's 760 nursing homes have been stocking aquariums, hanging art, potting palm trees, and setting their dinner tables with cloth napkins — all to get praise and money. The homes are part of a $22.5-million state program called QUIP, the quality incentive program.

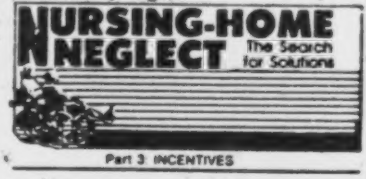
Like many states, Illinois has had a decade of nursing-home scandals, particularly in Chicago, and periodic efforts at reform.

"The reforms haven't worked. Punishment doesn't work. Fines don't work. QUIP is working," said program official Connie Cheren. It's the newest of several plans that try to get nursing homes across the nation to offer more and better care by rewarding them.

The administrator of Chicago's largest nursing home, a participant in QUIP, says he is pleased.

"They are trying social engineering — the use of the proverbial carrot — and it is working. QUIP is going to create a major revolution, and a good one, in nursing-home care in Illinois," said Ed Farmilant, administrator of the 450-bed Somerset House.

But some incentive plans have run into problems.



"Incentives are an interesting idea. But there is no such thing as an incentive that can't be ripped off. It doesn't exist," said David Schulke, a nursing-home reformer from California who is now an aide to the U.S. Senate's Special Committee on Aging.

Schulke said such plans work

See INCENTIVES, Page A-16

Cash incentives paying off in quality nursing care

FROM PAGE A-1

only if enforcement is tough.

Illinois agrees and has beefed up its monitoring system by sending 134 QUIP nurses to its Medicaid homes. Part watchdog, part fairy godmother, the nurses are there to monitor care, but also to give out the QUIP money.

QUIP pays homes up to $2 extra per day per patient for improvements in care, rewarding changes ranging from bringing in goldfish to hiring more nurse's aides. The QUIP nurse's job is to see that patients who need a specialist get to see one and to stop homes from "planting conked-out patients in front of television sets all day," as Mrs. Cheren put it.

A 15-year veteran of nursing-home reform, Mrs. Cheren, deputy director of Public Aid, Illinois's Medicaid agency, is a QUIP cheerleader.

Even before first reports were in, Mrs. Cheren said, she knew in mid-June that QUIP was having an effect when she tried to buy a fish tank for her own three children.

"The pet store told me there wasn't a 16-gallon tank to be had in the county because the nursing homes had bought them all. The stores don't even call them fish tanks anymore, now it's 'QUIP tanks.'"

The idea of rewarding homes for good behavior isn't new.

Gearing bonuses to patient health

In Santa Monica, California's Rand Corporation took the idea of paying extra for good care to the extreme.

In a 1981 study, Rand researchers Robert and Rosalie Kane tested a system that would have paid four mostly Medicaid nursing homes in the Los Angeles area extra money when patients got better and withheld the money if they got worse or died.

Playing a role that would be taken by state inspectors, researchers examined patients and set individual goals for each. (If the plan was put into effect, state inspectors would discuss each case with the nursing home to agree on what the goals should be.) Three months later, they came back, reexamined the patients, and tallied scores for the homes.

If a patient had improved, the home got extra points. If he had deteriorated, points were subtracted. Since it was only a test, no money was actually handed out, but the homes would have stood to gain or lose about $100,000 a year, depending on how well the patients did. Kane said that of the four homes, two would have gained, one would have lost, and one would have stayed the same.

Rand concluded that its system of measuring "patient outcomes" was "sensible and feasible." Now the corporation is looking for a state willing to test it on a wider scale.

Robert Kane, who got a three-year, $500,000 federal grant for the project, said the program "was my idea, my pet project." He got the idea in Europe, where he visited nursing homes and found the care to be much better and more humane, mostly because the homes were not not profit-making entities: They were run either under socialized medicine or by charitable institutions.

The American way

"We asked ourselves, how can we come up with something American? This is a country where profits rule. We decided to use this as a strong point. That led us in this direction," said Kane.

Kane, who in August left Rand to become the dean of the University of Minnesota's School of Public Health, said he is ready to lend his expertise to help states set up such a program, but that so far there are no takers. One criticism has been that there seems to be too little cost control in the project, though Kane disputes that.

The Rand study would reward nursing homes after they proved they had given patients extra care. Maryland says it has been successful in paying them upfront.

Three years ago, Maryland hospitals were burdened with an overflow of sick, elderly patients who needed nursing-home beds. But those 23,000 beds were 98-percent filled, mostly with patients not as sick as the ones waiting in the hospitals.

Today, the healthier patients are being treated in day-care and home-care programs, and "heavy care patients" are in the nursing homes.

What happened? Maryland doubled the money it paid homes for taking the patients needing the most care. Payment went from $34 a day to a maximum of $71 a day. But since relatively few patients needed the highest level of care, the average increase per patient per day worked out to $3.95. (That added about $5 million to the state's annual Medicaid expenditure.)

Known in health-care circles as the "case-mix reimbursement model," the Maryland approach is being watched with interest by other states and is highly touted by the nursing-home industry.

Reimbursement for needed care

The idea is to pay for the care needed, as opposed to paying a flat rate. For instance, a patient needing turning and positioning brings a Maryland nursing home $2.90 more a day. For taking care of a patient with severe bedsores, a home is paid an extra $24.69 a day.

But without strict enforcement to see the money goes to care, the program can be a gold mine for an unscrupulous or incompetent operator. The program already has had a nursing-home scandal.

Last October, a home in Baltimore was charged with taking in heavy-care patients to get the extra money but failing to give them the extra care they needed.

"They had to rush a patient to the hospital with a gangrenous ulcer that apparently resulted because the staff did not know how to care for it," said Joseph Millstone, Maryland's acting chief of long-term care.

At the Maryland State Health Department, Licensing Director Henry Schwartz said the facility, the Pall Mall Nursing Home, had been banned from admitting new patients. But improvements have been made, and the state plans to lift the ban.

Millstone said Maryland has to strengthen enforcement to make sure operators deliver the care that has been paid for in advance.

"The program is extremely vulnerable to abuse by unscrupulous operators, because they get the money upfront, whether they spend it on care or not," said Millstone.

Limited resources

Such abuse of the system is hard to track, said Schwartz. With 40 surveyors for 800 facilities (200 nursing homes), his resources are strained.

Bills that would have increased enforcement powers, including instituting fines, were defeated by the state legislature this year, he said.

In Illinois, Mrs. Cheren said QUIP guards against such abuse by having the QUIP nurses on duty at all homes. Critics have charged that the permanent placement of those nurses is a weakness, saying a nurse could become overly sympathetic to the nursing homes at which she works.

"I've got real problems with the idea," said Janice Caldwell, who administers Medicaid for the State of Texas and formerly worked for the Federal Health Care Finance Agency, writing nursing-home inspection guidelines.

"Any nurse who's in the same place day after day is going to get sympathetic to the nursing home. Or feel pressured."

Mrs. Cheren's answer to that potential problem is to be sure that her nurses get their sympathy from their peers. "We spend a lot of time in the field making sure that our nurses feel their support is coming from us, so they don't look to the nursing home to get it," she said. Nurses get a visit from Mrs. Cheren at least every two weeks. Nurses are also rotated to new assignments after four to six weeks.

Conflicting lines of authority

Another criticism is that QUIP can find problems but must rely on the state health department to enforce regulations.

"QUIP people are on a collision course with the state health department," said a nursing-home expert who requested anonymity. "QUIP is sending nurses out to look for ways to improve quality, and instead they are finding [licensed] nursing homes that are barely feeding people."

Mrs. Cheren agreed that there may be places that are too far gone for QUIP to fix them, particularly in Chicago. But she said QUIP nurses will be able to help health officials build cases against bad homes to get changes made or have them closed.

"We have already closed down a problem facility in Chicago, and we're getting ready to move on another one," she said.

"And as you move the mediocre homes up to being good homes, and the good to excellent, you bring the bad ones up to mediocre," she said. "They can no longer point the finger at the other guy and say, 'You think I'm bad, take a look at him.'"

So far, morale is high, and interest in QUIP is growing.

"For years, the industry has been saying, 'Just tell us what you want, tell us what you want.' Well, now we're telling them," Mrs. Cheren said.

TOMORROW: Suing to punish nursing-home outrages can be a waste of time.

Bruce Locklin and Barbara Gardner contributed to this report.

THE RECORD, WEDNESDAY, OCTOBER 2, 1985

Old life is cheap under state law

By Gale Scott
Staff Writer

In New Jersey, it can be cheaper for nursing-home owners to kill patients than to injure them.

That is because of a law that stops survivors from suing a negligent party for their own pain and suffering over a family member's wrongful death.

Three families of elderly people have sued the Bel Air Manor nursing homes this year for killing their relatives. The most they stand to collect is hardly more than the money for the funeral bills.

Not much value

But families of elderly people who died similar deaths in Texas — deaths from gangrene and infected bedsores — have filed multimillion-dollar lawsuits.

New Jersey is one of 28 states where old people's lives do not have much monetary value, nor do the lives of children and the disabled. A movement is on to change the law and treat people as more than wage earners measured by their potential productivity.

Alan Medvin of the Medvin and Elberg law firm in Newark and a former president of Lawyers Encouraging Government and Law, a Trenton lobbying group, has pushed to change the law ever since he represented the family of a teen-ager killed in an industrial accident.

Medvin said he will never forget the case. "It was one of the most horrible I can recall," he said.

A 19-year-old college sophomore working the night shift at a plastics factory in Somerset County in the summer of 1977 got his head caught in the presses of an injection molding machine. Said Medvin:

"When they found him in the morning, he had completely vaporized from the middle of his torso up. He had no head. He had no upper chest. He had no gray matter they could find — the machine had caught him with such force."

It was a clear case of employer negligence and one that might have resulted in a multimillion-dollar lawsuit in many states, he said. But when the family sued, they got $12,000. That was the approximate value to them of their son's services as an occasional baby-sitter and lawn-cutter.

NURSING-HOME
NEGLECT
The Search for Solutions

Part 4: THE COURTS

"Kids have no monetary value," Medvin said.

In Washington, Patricia Nemore, who works for the National Senior Citizen Law Center as one of four staff lawyers and nursing-home patients' advocates, said that opening the door to such claims — tort actions — could have a good effect on nursing-home care. "It wouldn't take too many big judgments to frighten nursing homes into giving better care," she said.

See LIFE, Page A-6

Elderly life is cheap, as defined by state law

FROM PAGE A-1

Robert Brown, a professor at the University of Detroit Law School and a nursing-home law expert, agreed:

"I think it's a deterrent thing. If nursing-home operators believed that if they didn't really watch their step, train their staff well, and supervise their staff well, and themselves toe the line, that there would be some fire-breathing lawyer on their doorstep ready to sue them up to the limits of their insurance coverage — I think there's some chance you'd get the kind of good caution that is desirable."

Ms. Nemore said she thinks that is particularly true in states like New Jersey, where by law punitive damages cannot be covered by insurance but must come out of the negligent party's pocket. (This is the law in about 25 states, says Jeff Palca of the Insurance Information Institute in New York.)

The relatively small awards that result from New Jersey's restrictions on damages often are only a slight punishment to the guilty party. And the fact that the awards can be less than the cost of filing a suit may discourage people from going to court, Medvin said.

The biggest irony, he said, is that negligence that results in death can cost the negligent party far less than negligence from which the victim recovers.

In a case where a nursing-home patient is disabled by bedsores caused by negligence, and a suit is filed while he is alive, even if the case is not settled until after the plaintiff dies, the injury award may be substantial. One such award made in New Jersey two years ago was for $165,000, said Ms. Nemore, of which $100,000 went to the estate and $65,000 to the widow.

Little more than funeral expenses

But if the patient dies before the suit is filed, his family can collect little more than funeral expenses. Sometimes when a lawyer proves the victim suffered greatly before dying, the courts have given the victim's estate some compensation, but not much.

Medvin thinks that situation is an outrage. "It is offensive to me as a human being," he said. He thinks the guilty party should have to pay heavily. "The hardest thing I had to do in that Somerset case was tell that family they could have gotten more damages if their son had just broken a leg," Medvin said.

State Sen. Richard Van Wagner, D-Middletown, has introduced a bill that would permit relatives to sue for loss of companionship. The bill originally called for awarding such relatives compensation for their mental anguish as well, but it was modified to please the insurance industry.

Nevertheless, Medvin said, the bill would open the door to substantially larger awards. "The insurance companies aren't exactly jumping up and down for joy with this bill either," he said.

"We strongly support the bill as it now stands," he said, "because the significant loss that is felt by surviving family members is companionship."

The bill is in the Senate Judiciary Committee, and Van Wagner thinks he can get it scheduled for a hearing and ready for a vote before the legislature adjourns.

'More and more people suing'

"I think we have a decent shot at passage," he said.

The insurance industry opposed the original bill, saying it would raise insurance premiums for many businesses and institutions, a cost that would be passed on to consumers. The industry would rather reverse the trend toward bigger awards:

"We would like to see caps on non-economic damages, such as companionship," said industry spokesman Palca, whose organization represents 200 insurance companies.

"There are more and more people suing, and the awards are higher and higher," he said. "If we are paying out more, we have to ask for rate increases."

Medvin says that allowing such suits did not increase insurance premiums in Delaware, which changed its law in 1982 to permit damages for mental anguish of survivors. He said that even if there are some substantial jury awards, that cost will be spread out enough so that the ratepayers will not notice much difference.

And once those big awards begin to have an effect as a deterrent, there could be less negligence and fewer wrongful deaths, he said.

"My answer to anyone who says changing the law would just increase insurance premiums is that there is absolutely no data to support that claim," he said.

But the insurance industry counters that Delaware's three-year-old law is too new to have caught on and that it is too early to tell whether court awards will raise rates.

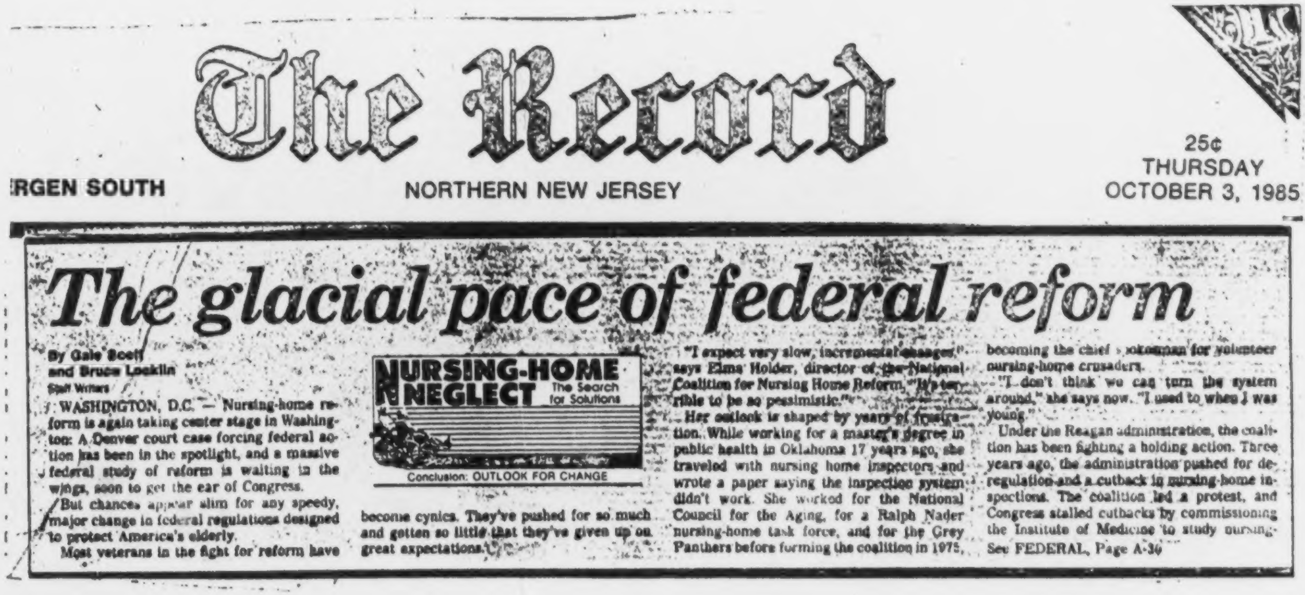
Ms. Nemore said that even if those rates do rise, the public will benefit.

"The trend is definitely to more suits, and more states changing their laws to permit them," she said.

In New Jersey, Medvin said, it will take public awareness to get the law passed. "Most people don't even realize that there is such a restrictive law until something happens to them," he said.

TOMORROW: The outlook for federal reforms.

Staff writer Bruce Locklin and research assistant Barbara Gardner contributed to this report.



The Record

RGEN SOUTH

NORTHERN NEW JERSEY

25¢
THURSDAY
OCTOBER 3, 1985

The glacial pace of federal reform

By Gale Scott
and Bruce Locklin
Staff Writers

NURSING-HOME NEGLECT The Search for Solutions

Conclusion: OUTLOOK FOR CHANGE

WASHINGTON, D.C. — Nursing-home reform is again taking center stage in Washington: A Denver court case forcing federal action has been in the spotlight, and a massive federal study of reform is waiting in the wings, soon to get the ear of Congress.

But chances appear slim for any speedy, major change in federal regulations designed to protect America's elderly.

Most veterans in the fight for reform have become cynics. They've pushed for so much and gotten so little that they've given up on great expectations.

"I expect very slow, incremental changes," says Elma Holder, director of the National Coalition for Nursing Home Reform. "It's terrible to be so pessimistic."

Her outlook is shaped by years of frustration. While working for a master's degree in public health in Oklahoma 17 years ago, she traveled with nursing home inspectors and wrote a paper saying the inspection system didn't work. She worked for the National Council for the Aging, for a Ralph Nader nursing-home task force, and for the Grey Panthers before forming the coalition in 1975, becoming the chief spokesman for volunteer nursing-home crusaders.

"I don't think we can turn the system around," she says now. "I used to when I was young."

Under the Reagan administration, the coalition has been fighting a holding action. Three years ago, the administration pushed for deregulation and a cutback in nursing-home inspections. The coalition led a protest, and Congress stalled cutbacks by commissioning the Institute of Medicine to study nursing-

See FEDERAL, Page A-36

Federal reform moves at glacial pace

FROM PAGE A-1

home regulation.

This fall, the institute is completing its two-year, $1.5 million report and putting the issue back in Congress's lap. But the man most likely to lead reform efforts, Rep. Henry Waxman, D-Calif., isn't optimistic.

"It's not going to be easy with this administration's commitment to go in the opposite direction," Waxman said in a telephone interview.

The six-term congressman, who heads the health and environment subcommittee, has built a reputation as a skillful tactician on issues he cares about, such as the Clean Air Act.

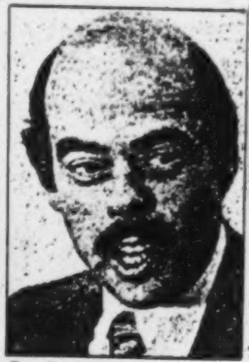
Waxman said the nation's bad nursing homes are in the Reagan administration's ideological blind spot, unrecognized as a problem because they don't fit in neatly with deregulation and free-market theories.

"I think the administration is under the impression that there is some kind of market system out there that will take care of assuring the quality of care," Waxman said. "In nursing homes, [patients] are just not well enough to fight for their best care. That's why government must be, should be, involved."

A spokesman for the Department of Health and Human Services said the administration no longer favors cutting back on nursing-home inspections and is eager to see the Institute of Medicine's report.

The administration's position is that isolated instances of nursing-home neglect don't prove that present inspection methods are ineffective — the bad homes could be aberrations.

Rep. Claude Pepper
Leading reform effort



Rep. Henry Waxman
"We've got to go forward"

"I'm hoping that the [institute] study will shed some light on that," said Thomas Moreford, a deputy director for quality standards. "It's difficult."

Two thousand miles from Washington, another voice is demanding and winning federal attention for nursing-home patients.

John Holland, a 38-year-old Denver lawyer, last year won a 10-year court battle to compel federal authorities to guarantee quality care in any nursing home getting federal funds.

The nation's top health official, Margaret Heckler, soon to be replaced as secretary of health and human services, has been ordered by a federal court to find a way to make sure the federal government knows what goes on inside nursing homes and other institutions that get Medicaid money. So far, Heckler's response has been to change the nursing home survey form, adding a section that quizzes patients about their care.

Nevertheless, experts in nursing-home policy are amazed at the scope of the court's decision and Holland's triumph in the David-and-Goliath contest.

"It's like a totally unanticipated success by the guerrillas in blowing up the main ammunition dump," said Bruce Vladeck, author of "Unloving Care," a detailed analysis of nursing-home policy failures.

But Holland is another crusader who has become a cynic. The first federal responses to the court order have convinced him that health officials are resisting significant change.

"We have a cruel, uncaring government pretending not to know anything," said Holland. He's hoping that either the Denver court or Congress will complete his victory by refusing to accept token changes.

Another reform effort, this one aimed at prosecuting unscrupulous nursing-home operators, is being led by Rep. Claude Pepper, D-Fla., an 85-year-old congressman long associated with the cause of the elderly.

Pepper, head of the House health and long-term care subcommittee, proposed legislation this summer that would require all state Medicaid-fraud units also to investigate neglect and abuse. Under Pepper's plan, Washington would pay most of the added cost.

Proposals to increase federal spending have to swim against the current tide in Washington, but Pepper's initiative is getting some attention. Actor Kirk Douglas, who last Sunday dramatized the plight of America's elderly in a television film, has been rallying support.

Pepper is trying to close off an option that was given to the states in 1977 when Congress approved the Medicaid Fraud and Abuse Act. New York State's system was used as a model, with one significant change. New York's Medicaid investigators handle both fraud and abuse complaints. Congress allowed state units to focus solely on fraud, and to refer patient-care cases to other agencies.

Peter Reinecke, Pepper's research director, said most states followed the dollar and created fraud squads that bring in more money in recoveries than they spend on investigations.

New Jersey's Medicaid-fraud unit made a big profit last year — $1.8 million spent and $4.8 million recovered. But the unit does few patient neglect or abuse investigations — only seven in the last three years.

The New Jersey unit was eligible for another $1 million in federal money, which it could have earmarked for such cases, but because the federal emphasis is on fraud prosecution, that is where the money goes.

Even in New York, where state Medicaid investigators handle both fraud and abuse, there are "paltry few" successful neglect and abuse cases, said Edward J. Kuriansky, a deputy attorney-general who supervises the 350-person Medicaid investigative team. One reason is that frail, elderly patients don't make good witnesses. Also, the New York unit devotes less than 10 percent of its resources to patient abuse and neglect cases, and hasn't tried such aggressive techniques as the use of undercover investigators.

But Kuriansky believes his office serves as a strong deterrent to nursing-home neglect by investigating all complaints, and by building solid fraud cases and revoking licenses.

"There is also sometimes a correlation," he said, "like the way they used to prosecute Al Capone on tax evasion."

Kuriansky said he believes human greed is the root cause of nursing-home horrors.

Edward J. Kuriansky
Few successful neglect cases

"I know you can't legislate compassion," Kuriansky said. "Let a person like that into the business, like [The Record] found in Bel Air, like the Bergmans, there's no way you can protect people against those kind of people."

For Representative Waxman, the likely key figure in the next push for federal reform, such disclosures demand action.

"If a scandal like the Bel Air case can exist in an affluent community in a state like New Jersey, which has a reputation for a strong regulatory climate, one has to assume that such scandals can exist anywhere.

"We can't assume at the federal level that the states are going to take on this responsibility. The Institute of Medicine will give its recommendations as to what standards of quality we have to insist upon, and we've got to go forward."

Researcher, Barbara Gardner contributed to this report.

[COMMITTEE STAFF NOTE: The following documents describe conditions found in two southern California skilled nursing facilities by inspectors representing the State Health Department. As a result of these violations, fines were assessed by the State Health Department.]

State of California—Health and Welfare Agency

Department of Health Services

Citation Number(s)
944-073-067
944-073-068
944-073-069
944-073-070
944-073-071

CITATION REVIEW CONFERENCE DECISION

California Health and Safety Code, Section 1428 requires that at the conclusion of a citation review conference, the director's designee either affirm, modify, or dismiss the citation, the proposed assessment of civil penalty, or the date of correction of a violation. The following are the conclusions and decisions in accordance with the above law.

Licensee Inc.,	Type of Ownership Corporation	Capacity 296
Licensee Address (Street) Boulevard	(City)	(State) California
Facility	Facility Type Skilled Nursing Facility	Facility Number
Facility Address (Street) Boulevard	(City) California	(Zip) Phone Number -1

(Zip)

Background:

On the date of May 31, 1985 the above numbered citation(s) and penalty assessment(s) were issued to the named licensee for alleged violations of patient care standards occurring in the above-named facility.

On the date of June 6, 1985 a request for a Citation Review Conference was received from the licensee/designee in the district licensing office at 313 North Figueroa Street, Los Angeles, CA 90012

On the date of July 29, 1985 and time of 10:30 a.m. at the location of 313 North Figueroa Street, L.A., CA Room 828 a Citation Review Conference was scheduled and held.

In attendance at that conference were: Victor Arkin (Hearing Officer, Dept. of Health Services) Rosa Johnson (Health Facilities Surveyor) , Atty. ( ) John A. Bavaro, M.D., M.D., M.D. M.D. ( )

Conference Comments (Explain Postponements, Continuances, and Rescheduling):

Facility waived the 5 day requirement.

In accordance with law, the following are the findings, conclusions, and ordering from this conference:

Code Section	Conclusions N	D	R	C	Explanation of Conclusions
95H-073-067 72311(a)(1) (A)	X				Class "A" Citation - Patient Care - UPHELD
Assessed $5,000. Corrected					Facility failed to show that it agressively and systematically provided a
					continuing assessment of the patient's needs. The patient's attending
					attending physician testified at the citation review conference that he was
					aware of the patient's weight loss and in view of the patient's diagnosis,
					Huntington's Chorea, the loss was unavoidable. Furthermore, counsel for
					the facility argued that the omissions were within the domain of poor
					record keeping and not reflective of the care given. Nevertheless, no
					facts were presented to negate the original conclusion that the continu.
					assessment for patient A either was non-existant or inadequate.

HS 828 (6/85)

Page 1 of 3 Page

94H-073-067
94H-073-068
94H-073-069
94H-073-070
94H-073-071

In accordance with law, the following are the findings, conclusions, and ordering from this conference.

Code Section	Conclusions N	D	R	C	Explanation of Conclusions
94H-073-068	X				Class "B" Citation - Patient Care - UPHELD
72311(a)(3) (D)					
Assessed $500.					
Corrected					
94H-073-069 72313(a)(2)	X				Class "A" Citation - Patient Care - UPHELD.
Assessed $3,000.					
Corrected					This patient had a specific order for ambulation by a physical therapist. The order was not followed and ambulation was performed by a nurse aide. The record also shows the patient in certain instances only poorly tolerated ambulation. The attending physician attended the citation review conference and stated that despite the multiple entries made by him in the patient's record relating to a gangrenous ulcer on the hip - that the ulcer was "not gangrene". In addition, the physician testified that despite the order for treatment by physical therapist, he was aware of the treatments received by the patient and satisfied with the care given the patient.
					The physician, however, did not explain why given an opportunity of three months (March, April and May, 1985) he did not discontinue the order for a Physical Therapist.
95H-073-070 72311 (a) (1)(A)	X				Class "B" Citation - Patient Care - UPHELD.
Assessed ,000.					Facility failed to show that it systematically provided a continuing assessment of needs for patients "B", "C", "D", and "E".
Corrected					

Citation Number(s)
94H-073-067
94H-073-068
94H-073-069
94H-073-070
94H-073-071

In accordance with law, the following are the findings, conclusions, and ordering from this conference

CODE SECTION	Conclusions N	D	R	C	EXPLANATION OF CONCLUSIONS
94H-073-071	X				Class "B" Citation - Patient Care - UPHELD
72315(f)(1)					
Assessed					No evidence was presented to invalidate surveyor observations as noted
$1,000.					in the citation. Facility staff failed to change positions of patients
Corrected					"C", "F", and "G" for extended periods of time.

Order: By the authority delegated to me under Section 1428 of the California Health and Safety Code, I hereby affirm, modify, and/dismiss the above violation according to the findings and conclusions stated above.

Appeal Rights:

A licensee may contest the citation review conference decision.

(a) If the licensee desires to contest a Class "AA," "A," or Class "B" *and* a "AA" or "A" citation review conference decision, the licens must notify the district administrator or his or her designee, in writing, by registered or certified mail, within five business days after rece of the citation review conference decision. Upon notification by the licensee, the Department shall refer the matter immediately to t Attorney General for appropriate action.

(b) If the licensee desires to contest a citation review conference decision involving a *Class "B" citation(s) only*, the licensee must notify the district administrator or his or her designee, in writing, by registered or certified mail, within five business days after receipt of the citation review conference decision. However, unlike (a) above, the matter will not be referred by the Department to the Attorney General. It is the licensee's responsibility to further pursue the appeal. See Sections 1428(c) and (k).

DEFINITIONS:
N – No Change
D – Dismissed
R – Reduced
C – Change D:
Correction

Coordinator's Name
Victor Arkin, Hearing Office Victor Arkin 8/8/85

[illegible] California Administrative Code, Title 22, Div. [illegible]

, Inc.	Date 5/31/85	Time 1 05	☐ ☒
	Profit Corp.	206	Survey
	California		
Sanitarium	[illegible]		
	CA		

Each citation will identify the code, title and section violated, the class of violation, the requirement of law or regulation, the nature and location of the violation and the time limit for correcting the violation.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
94H-073-067	CLASS "A" VIOLATION - PATIENT CARE		
Title 22, CAC 72311(a)(1)(A)	Nursing service shall include the identification of care needs based upon continuing assessment of the patients' needs.	$5,000	5/31/85
	On 5/20/85, patient "A" was observed in bed and appeared to be underweight. She had constant spastic movements of her head and all extremities.		
31-85 $5000	On 5/24/85, the health record of patient "A" was reviewed. The record revealed the 30 year-old female patient's height was 5 feet, 5 inches and that in December 1984, she weighed 105 pounds. For January 1985, the record indicates "unable" and no weight is recorded. In February 1985, the patient weighed 95 pounds. In March 1985, the record indicates "unable" and no weight is recorded. For April and May 1985, there is no comment and weight recorded. There was no evidence of an assessment by the dietary consultant since 3/20/84.		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice

Signature

Name

Title Administrator

Ralph Lopez, Chief
Health Facilities Division
313 No. Figueroa St., Room 217
Los Angeles, Ca. 90012

Vivian Porath
Citation Coordinator
(213) 974-7863

NOTE: In accordance with California Health and Safety Code, failure to correct violations is grounds for suspension or revocation of your license.

HS 616 (4/85)

Page 1 of 11 Page(s)

[illegible]

068, 069, 070
071

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	When the patient was weighed at my request on 5/24/85,		
	she weighed 79.8 pounds. Between December 1984 and		
	February 1985 she lost 10 pounds, yet there was no		
	evidence of frequent assessment of weights. Sub-		
	sequently, the patient lost another 15.2 pounds, an		
	average of 5 pounds per month.		
	The facility's staff failed to continually assess this		
	patient's weight and dietary needs. That failure pre-		
	sents an imminent danger and substantial probability		
	that serious physical harm would result therefrom		
	to patient "A" and to all other patients in the		
	facility.		
9411-073-068	CLASS "B" VIOLATION - PATIENT CARE		
Title 22, CAC	Nursing service shall include notifying the attending	$500.00	5/31/8
72311(a)(3)(D)	physician promptly of a change in weight of five		
	pounds or more within a 30 day period unless a		
5-31-85	different stipulation has been stated in writing		
$500	by the patient's physician.		
	On 5/20/85, patient "A" was observed in bed and		
	appeared to be underweight. She had constant		
	spastic movements of her head and all extremities.		
	On 5/24/85, the patient's health record was reviewed.		
	The record revealed the 30 year old female patient's		
	height was 5 feet, 5 inches, and that in December		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title Administrator

Page 2 of 11 Page(s)

HS 816Ai (4/85)

[illegible] 070, 071

[illegible] (HS 816). When the violation [illegible] for additional pages.

[illegible]	Class and Nature of Violation	Penalty Assessment	Deadline for Compliance
	1984, she weighed 105 pounds. For January 1985,		
	the weight record indicates "unable" and no weight		
	is recorded. In February 1985, the patient's weight		
	was 95 pounds, a 10 pound loss since December 1984.		
	There was no evidence of physician notification of		
	that 10 pound weight loss. Subsequently, the patient		
	has lost an additional 15.2 pounds as evidenced by		
	the weight of 79.8 pounds recorded after this		
	surveyor requested her to be weighed on 5/24/85.		
	The facility staff failed to notify the attending		
	physician of the patient's 10 pound weight loss		
	between December 1984 and February 1985, since there		
	was no weight for January 1985. That failure has a		
	direct relationship to the health and safety to this		
	patient and to all other patients in the facility.		
94H-073-069	CLASS "A" VIOLATION - TREATMENTS		
Title 22, CAC	Treatments shall be administered as prescribed.	$3,000	5/31/85
72313(a)(2)			
	On 5/24/85, the record of patient "B" was reviewed.		
5-31-85	This revealed that the 76 year old male patient was		
$3000	readmitted on 2/26/85 after care in an acute hospital		
	for a subcapitol fracture of the right femur. The		
	admission orders included: (1) "may ambulate patient		
	with P.T., weight bearing on left leg OK as tolerated";		
	(2) "keep knee splint on X 8 weeks to prevent		

Name of Evaluator Rosa Johnson, RN, HPS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title Administrator

Page 3 of 11 Page(s)

HS 816Ai (4/85)

[illegible]

[illegible] for additional pages.

Section	Class and Nature of Violation	Penalty Assessment	Date [illegible] Corr[illegible]
	prosthesis dislocation. May be removed by P.T. for ambulation and do ROM of extremities".		
	The orders for March, April and May 1985 included both orders (1) and (2) which had not been discontinued by the physician.		
	The physician's progress notes on 4/9/85 indicates "swelling right lower leg" and on 4/13/85 indicates local infection of right hip. In spite of those observations, the restorative nurse #1 continued to ambulate and give range of motion to "lower extremities."		
	The physician's progress note on 4/18/85 indicate the presence of a "gangrenous lesion over the surgical scar right upper thigh, right leg swelling and cyanotic". In spite of those observations the restorative nursing record reveals the patient was ambulated and given range of motion.		
	On 4/16/85 and 4/23/85, the restorative nursing record indicated the patient was tolerating ambulation "poorly". There was no evidence of reporting the observation to the nurse in charge. On interview the restorative nurse #1 stated she reported the observations.		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title Administrator

[illegible]

071

This form is used as a supplement to the [illegible] Notice (HS [illegible]). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Date [illegible] Completed
	There was no care and assessments made by a physical therapist as ordered. Subsequently, an infected hip was given range of motion, the patient was ambulated when his leg was swollen and cyanotic, and the patient's poor toleration to ambulation was not reported to the charge nurse.		
	On interview a licensed nurse #1 stated she thought the "P.T. meant patient". The administrator stated "if he was a rehab person, he would not have come back here", and facility has a contract with a physical therapist for "consultation and two in-services" a year.		
	The facility failed to administer treatments as ordered. The failure presents an imminent danger and substantial probability that serious physical harm would result therefrom to patient "B" and to all other patients in the facility.		
94H-073-070 Title 22, CAC 72311(a)(1)(A)	CLASS "B" VIOLATION - PATIENT CARE Nursing care shall include the identification of needs based upon initial and continuing assessment of patient needs.	$1,000	5/31/85
5-31-85 $1000	On 5/24/85, the health record of patient "B" was reviewed. The physician's progress note on 4/9/85 revealed there was swelling of the patient's right leg.		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice

Signature

Name

Title [illegible]

Page 5 of 11 Page(s)

HS 616Ai (4/85)

SECTION 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s): [illegible] 071

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	On 4/13/85, the physician's progress note revealed a local infection of the right hip.		
	There was no evidence of nursing assessment of the swollen leg between 4/9 and 4/13/85. On 4/13/85, licensed nurses note indicate "right leg still swollen". Subsequently, there is no evidence of nursing assessment on the swollen leg. However, the physician's progress note on 4/18/85 indicate the right leg was swollen and cyanotic, and a "gangrenous lesion over the surgical scar right upper thigh". The licensed nurses notes fail to include observation of the cyanosis. The weekly progress notes on 4/20/85 fail to reflect the edema, cyanosis or lesion on the right leg. On 4/20/85, nurses progress note indicate "skin intact", but the Decubitus Report indicated on 4/18/85, a 1½ in. x ½ in. lesion was present.		
	Furthermore, the health record revealed the patient was admitted on 2/26/85, at which time no weight or length of the patient was recorded. The patient weighed 120 pounds when first weighed on 4/4/85, 37 days after admission. The patient's length was documented as 5 feet, 9 inches after I requested a measurement.		
	The facility's staff failed to continually assess the		

Name of Evaluator: Rosa Johnson, RN, HFS II

Signature of Evaluator: Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice

Signature:

Name:

Title: [illegible]

HS 816A1 (4/85)

SECTION 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s) [illegible] 068, 069, 070 071

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	patient's swollen leg, failed to monitor the cyanosis, and failed to obtain a length and weight on admission. That failure has a direct relationship to the health and safety of the patient and all other patients in the facility.		
	On 5/22/85, the health record of patient "C" was reviewed. The record revealed the 73 year old patient was admitted on 10/02/79. The patient's diagnosis included Endometrial Carcinoma, Hypertension and Alzhiermer's Disease. The record of weights revealed the patient's height was 5 feet, 2 inches. The patient weighed 126 pounds on 10/4/84 and lost an average of 4 pounds per month from 10/4/84 to 3/6/85, at which time she weighed 106 pounds.		
	On 4/4/85, the last recorded weight was 94½ pounds which indicated 11½ pound weight loss. When the patient was weighed at this surveyor's request on 5/22/85, she weighed 73 pounds. An additional 21½ pounds was lost between 4/4/85 and 5/22/85. There was no evidence of an assessment by the dietary consultant since 10/30/84 at which time the consultant noted the "patient needs to lose at least 18 pounds more".		
	The facility's staff failed to continually assess the patient's weight. That failure has a direct		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice

Signature

Name

Title

Page 7 of 11 Page(s)

HS 816Ai (4/85)

Violation or Citation Number(s) [illegible], [illegible], [illegible], 070, 071

SECTION 1424 NOTICE SUPPLEMENT

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	relationship to the health and safety to this patient and to all other patients in the facility.		
	On 5/20/85, patient "D" was observed to have a dry stage III ulcer on the lateral aspect of his right ankle that measured approximately 4 centimeters in diameter. The 76 year old male patient's health record was reviewed on 5/23/85.		
	The record of the patient's weight revealed the 5 foot, 7½ inch patient on 3/4/85 weighed 151¼ pounds and on 4/4/85 weighed 139½ pounds. The record revealed the physician was notified of the 12 pound weight loss. Subsequently, there was no evidence of continual assessment of the weight change. There was no evidence of assessment by the dietary consultant since 4/3/84.		
	The facility's staff failed to continually assess the patient's weight after a 12 pound weight loss was observed in a 30 day period. That failure has a direct relationship to the health and safety of patient "D" and to all other patients in the facility.		
	On 5/22/85, patient "E" was observed to have an		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title Administrator

Page 8 of 11 Page(s)

HS 816A1 (4/85)

SECTION 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s) [illegible]

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	edematous, discolored area involving the right eye-		
	brow and his left hand was edematous. On interview,		
	the director of nursing stated the patient had fell		
	on the previous day.		
	The patient's health record was reviewed on 5/23/85.		
	The patient's diagnosis includes history of subdural,		
	subarachnoid hemorrhage.		
	The licensed nurses note on 4/22/85, indicate that the		
	"patient was seen on the floor at 11:50 a.m., lying		
	on his right side in the main dining room"by nurse		
	assistant #1. The vital signs recorded were B.P.		
	120/70, P-68, R-20 and T-98.4.		
	The patient's temperature, pulse and respirations were		
	taken again by licensed nurse #2 who failed to record		
	the time of observation, but on interview stated the		
	observation was made at approximately 6:30 p.m.		
	The next assessment of the patient's vital signs was		
	on 5/22/85, 11-7 shift and no time is documented.		
	There was no evidence of assessment of neurological		
	signs such as reaction of pupils to light. There was		
	no evident of assessments between the initial visit		
	and 6:30 p.m., a period of approximately 6½ hours.		
	At that time, only the temperature, pulse and		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title [illegible]

Page 9 of 11 Page(s)

HS 816A1 (4/85)

SECTION 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s): [illegible]
[illegible]
071

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	respirations are recorded.		
	The facility's staff failed to continually assess vital signs after patient was found on the floor and observed to have a head injury. That failure has a direct relationship to the health and safety of this patient and all other patients in the facility.		
94H-073-071 Title 22, CAC 72315(f)(1)	CLASS "B" VIOLATION - PATIENT CARE Each patient shall be given care to prevent formation and progression of decubiti. Such care shall include changing position of bedfast and chairfast patients.	$1,000	5-31-85
5-31-85 1000	On 5/20/85, patient "F" was observed to have a stage IV decubitus on his coccyx. On 5/21/85, the patient was visited at 9:15 a.m., 10:05 a.m., 11:15 a.m., 12:20 p.m., 1:15 p.m., and 2:15 p.m. At each visit the patient was observed lying on his back with his right hand restrained to the right side of his bed and his left hand restrained to the left side of the bed. After the 12:20 p.m. visit, nursing staff had the patient sit in a chair while his bed linens were changed, but the position in bed was not changed between 9:15 a.m. and 2:15 p.m., a period of 5 hours.		
	On 5/21/85, patient "C" was visited at 9:15 a.m., 10:05 a.m., 11:15 a.m., 12:20 p.m., 1:15 p.m., and 2:15 p.m. At each visit the patient was observed		

Name of Evaluator: Rosa Johnson, RN, HFS II

Signature of Evaluator: Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature:

Name:

Title: Administrator

Page 10 of 11 Page(s)

SECTION 1424 NOTICE SUPPLEMENT

[illegible]

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	lying on her back with knees flexed and turned to the		
	left. The edematous left hand was not elevated.		
	There was no pillow or pad in the bed or at the bed-		
	side for elevating the edematous hand. The patient's		
	position in bed was not changed between 9:15 a.m. and		
	2:15 p.m., a period of 5 hours.		
	On interview at 2:15 p.m., nurse assistant #2 stated		
	that she needs to get some pillows.		
	On 5/21/85, patient "G" was visited at 9:15 a.m.,		
	10:05 a.m., 11:15 a.m., 12:20 p.m., 1:15 p.m., and		
	2:15 p.m. At each visit the patient was observed to		
	be lying on her back. The patient's position in bed		
	was not changed between 9:15 a.m. and 2:15 p.m., a		
	period of 5 hours.		
	A review of the care plan revealed the patient on		
	3/18/85 was "not feeding herself". The record		
	indicated a question of weakness. The nurse		
	assistants notes reveal the patient was fed.		
	The facility's staff failed to change the position of		
	patients "C", "P" and "G" to prevent the formation		
	and/or progression of decubiti. That failure has a		
	direct relationship to the health and safety of		
	patients "C", "P" and "G" and all other chairfast		
	and bedfast patients in the facility.		

Name of Evaluator Rosa Johnson, RN, HFS II

Signature of Evaluator Rosa Johnson RN

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title

Page 11 of 11 Page(s)

HS 816A1 (4/85)

*9411-073-067	72311(a)(1)(A)	$5,000	
9411-073-068	72311(a)(3)(D)		$500
9411-073-069	72313(a)(2)	3,000	

Below are the applicable civil penalty assessments imposed by the Department for each violation or citation listed in this NOTICE. "Repeat" Bs are marked by an asterisk. Citations subject to trebling are marked with two asterisks and the penalty assessment stated on the front-side of this NOTICE has been trebled.

Citation or Violation No.	Section Violated	Class "AA"	Class "A"	Class "B"	B*	B**
9411-073-070	72311(a)(1)(A)		5,000	$1,000		
9411-073-071	72315(f)(1)		3,000	1,000		
Penalty Assessment Totals			$8,000	$2,500		

Please note that no civil penalty need be paid for Class "B" violations which are corrected within the time specified unless it is a second or subsequent violation occurring within the period since and including the previous full annual licensing survey inspection or 12 months, whichever is greater, up to 15 months (see Section 1424(c)). The department refers to such violations as "repeats." Class "AA" and "A" violations are always subject to civil penalties even though corrections are made as required by the Department.

MINIMUM CIVIL PENALTY FOR CITATIONS WHICH ARE NOT CONTESTED

In lieu of contesting the citation or civil penalty assessment(s) on Class "AA", "A", or "B" violations, you may send to this office, within five business days of receipt by the licensee of this NOTICE, the minimum amount specified by law or 50 percent of the amount specified as the penalty assessment above, whichever is greater (1428, Health and Safety Code). The minimum amount specified by law for each Class "AA" violation is $5,000; Class "A" violation is $1,000; and for each Class "B" violation is $100. If you wish to send this amount in lieu of contesting the citation(s), please make your check payable to the "State Department of Health Services" and mail it to the licensing office as noted.

PENALTIES FOR REPEAT VIOLATIONS

*This B citation is a repeat of an earlier violation of the same regulation or statute.

#	DATE OF CITATION	CLASS "A" OR "B"	SECTION NO.

Pursuant to Section 1424(d), the penalty assessment noted above is due, irrespective of whether this B citation has been corrected within the time specified.

**Trebled Penalties

This citation is subject to trebling. An earlier violation of the same regulation or statute for which a penalty was payable occurred within the prior 12-month period and was not a citation that was 1) dismissed; 2) reduced to a Class "C"; 3) a class "B" citation involving patient's rights that the department determined did not have a direct or immediate relationship to the health, safety, security or welfare of the patients (see Section 1428(d) and (g)). (Note: penalties assessed pursuant to Sections 1424(e) and 1432 can not be trebled.)

#	DATE OF CITATION	CLASS "A" OR "B"	SECTION NO.

Therefore, you are required by law to pay the penalty assessment(s) noted above (see Section 1428(g)).

CONTINUING VIOLATIONS

If you do not complete the corrections by the dates specified in this NOTICE, you will be assessed an additional fifty dollars ($50) for each day each violation continues beyond the correction date.

CONTESTING

If a licensee desires to contest at a citation review conference, or directly to court, a citation or penalty assessment for a "AA", "A", or "B" issued with a "AA" or "A", or the date specified for correction of such a violation, the licensee must send a written statement, indicating which option is desired, to the licensing office specified on this form within five business days after the licensee receives this NOTICE. If a citation review conference is requested, it will be scheduled within five (5) business days after the licensing office receives your statement. If the licensee desires to go directly to Court, the citation will be referred by the department to the A.G. for appropriate action (Section 1428(a) and (b)). The licensee may also elect to submit the matter to binding arbitration pursuant to Section 1428(k).

If this NOTICE includes Class "B" citations only and the licensee desires a citation review conference or to adjudicate the validity of the citation(s) in municipal court, the licensee must send a written notice specifying which action is being taken to the licensing office specified on this form within five business days after the licensee receives this NOTICE.

NOTE: If the licensee desires to exercise the option to appeal a "B" only citation to court, it is the licensee's responsibility to file that action in accordance with Section 1428(c), Health and Safety Code. The licensee may also elect to submit the matter to binding arbitration pursuant to Section 1428(k).

Richard Wolfe
Signature of District Licensing Administrator/Designee

Richard Wolfe, L.A. County-East
District Administrator and District Office

NAME OF EVALUATOR Rosa Johnson, RN, HFS II

SIGNATURE OF EVALUATOR Rosa Johnson, RN

WEISSBURG AND ARONSON, INC
ATTORNEYS AT LAW
32nd FLOOR TWO CENTURY PLAZA
2049 CENTURY PARK EAST
LOS ANGELES, CALIFORNIA 90067-3273
TELEPHONE (213) 277-2223
TELECOPIER (213) 557-8475

[illegible]
[illegible]
[illegible]
[illegible]
PETER ARONSON
CARL WEISSBURG
RICHARD A. BLACKER
[illegible] RICHEY
JAY N. HARTZ
PATRIC HOOPER
MARK S. WINDISCH
J. MARK WAXMAN
ROBERT W. LUNDY JR.
KENNETH M. STERN
CARL H. HITCHNER
ROBERT D. SEVELL
MARSHALL R. FUSS
JOHN R. SPARKS
ROBERT M. DAWSON
LLOYD A. BOOKMAN
ROBERT B. MCCRAY
RICHARD F. SEIDEN

[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
[illegible]
JOEL M. GUTH
JAY T. LEVITT
PATRICIA BUCALO
DOUGLAS S. CUMMING
PETER M. GRANT
MARIANNE DOZIER
CRAIG T. CUDEN
ROBIN J. HUMPHRIES
RITA L. TUZON
BEVERLY A. TIFFANY
PAUL T. SMITH
RICHARD A. FRIEDMAN
MARY R. BARNES
PATRICIA E. BINSKEY

*OF COUNSEL

SACRAMENTO OFFICE
660 J STREET SUITE 480
SACRAMENTO CALIFORNIA 95814-2412
(916) 443-6005

SAN FRANCISCO OFFICE
ONE EMBARCADERO CENTER
SUITE 2201
SAN FRANCISCO CALIFORNIA 94111-3783
(415) 434-4484

PLEASE ADDRESS REPLY TO

Los Angeles

August 19, 1985

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Ralph Lopez, Chief
Health Facilities Division
Department of Health Services
313 North Figueroa Street, Room 317
Los Angeles, California 90012

Re: Consolidated Inc.
dba

Dear Mr. Lopez:

This office represents Consolidated Inc., dba . Please be advised that the licensee hereby contests and appeals the Department's decision following the Citation Review Conference regarding Citation Nos. 94H-073-067, 94H-073-068, 94H-073-069, 94H-073-070 and 94H-073-071.

Sincerely,

Robert J. Gerst/ae

Robert J. Gerst

RJG:al

[illegible] Number(s) [illegible]

You are [illegible] in violation of California Health and Safety Code [illegible] and/or California Administrative Code, Title 22, Div. 5

[illegible]	10-15-85	Sp.	[illegible]
[illegible] CORPORATION	Corporation	92	Survey
[illegible]	California		
Facility Name: [illegible] Convalescent Hospital	Facility Type: Skilled Nursing		
Street.	California		

Each citation will identify the code, title and section violated, the class of violation, the requirement of law or regulation, the nature and location of the violation and the time limit for correcting the violation.

[illegible]	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
92H-036-070	CLASS "B" Citation - Patient Care		10-15-85
Title 22, CAC			
Section	Each patient shall be provided care which shows		
72315(d):	evidence of good personal hygiene, including care of		
#24	the skin, shampooing and grooming of hair, oral		
	hygiene, shaving or beard trimming, cleaning and		
	cutting of fingernails and toenails. The patient		
	shall be free of offensive odors.		
Section	Each patient admitted to the facility shall have the		
72527(a)(10)	right to be treated with consideration, respect and		
	full recognition of dignity and individuality, including		
	privacy in treatment and in care of personal needs.		
	The facility utilizes adult, disposable briefs on all		
	their incontinent and foley catheter patients to control		
	soiling and to help in maintaining the patients' skin		
	integrity. However, on 9/30/85, during 6:00 a.m.		
	patient rounds, the following was observed:		

Name of Evaluator: Barbara Lee, R.N.
Dana Hall, R.S.

Signature of Evaluator: Barbara Lee, RN

Dana Hall

Ralph Lopez, Chief
Health Facilities Division
313 No. Figueroa St., Room 317
Los Angeles, Ca. 90012

Vivian Porath
Citation Coordinator
213. 974-[illegible]

Without admitting guilt, I hereby acknowledge receipt of the Citati
Notice.

Signature:

Name: ____

Title: ____

NOTE: In accordance with California Health and Safety Code, fa
to correct violations is grounds for suspension or revocat
of your license.

HS 816i (4/85)

Page 1 of 7 Page(s)

SECTION 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s)
92H-[illegible]
92H-[illegible]

This form is used as a Supplement to the Section 1424 Notice (HS 815). When the violations cannot all be listed on the notice, this form is used for additional pages

Section	Class and Nature of Violations	Penalty Assessment	Deadline Compliance
	Ten (10) of thirty-four (34) incontinent patients located on Station II (Rms. 19A, 33C, 34A, 35A, 35B, 36B, 38B, 39C, 40A, and 40B) exhibited extremely strong urine odors. Four (4) of these patients had super-saturated disposable briefs (33C, 34A, 38B, 39C) and six (6) patients had on dry, disposable briefs but still smelled strongly of urine (19A, 35A, 35B, 36B, 40A, 40B).		
	Eleven (11) patients in the facility had neglected mouth care signified by dried mucoid material and chapped, crac ked lips (2A, 19B, 19C, 22C, 31B, 33C, 34C, 36C, 39B, 40A, and 40B). Six (6) of these patients who were receiving continuous nasogastric tubefeedings had extremely dry, chapped lips and hardened mucoid material around their teeth, lips, and gums (2A, 19C, 22C, 33C, 34C, 39B).		
	In addition, no morning (AM) care was given to any of the patients prior to breakfast on 9/30/85. Patients were rolled up in bed without benefit of face and handwashing. Nurse assistants were not utilizing soaps and washbasins and no face cloths were available for use.		
	Subjecting patients to the above showed a lack of dignity and respect towards the patients. Good personal hygiene is important not only for the		

Name of Evaluator Barbara Lee, R.N.
Dana Hall, R.S.

Signature of Evaluator Barbara Lee, RN
Dana Hall

Without admitting guilt, I hereby acknowledge receipt of this Citation Notice.
Signature
Name
Title

HS 816 A (5/85)

FORM 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s) [illegible]
924-086-07
924-086-07

This form is used as a Supplement to the Citation 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline For Compliance
	health of the patient but also his her dignity as a		
	human being		
	FAILURE TO PROVIDE GOOD PERSONAL HYGIENE AS EVIDENCED		
	BY THE ABSENCE OF MORNING (AM) CARE. STRONG URINE		
	ODORS, AND NEGLECTED MOUTH CARE HAD A DIRECT RELATION-		
	SHIP TO THE HEALTH AND SAFETY OF PATIENTS.		
4-086-071	Class "B" Citation - PATIENT CARE		10-15-85
le 22, CAC			
. 72525(c)	The functions of the infection control committee shall		
(D)(1)	include, but not be limited to, establishing, review-		
	ing, monitoring and approving policies and procedures		
	for investigating, controlling and preventing infections		
	in the facility.		
. 72311(a)	Nursing service shall include identification of care		
(A)	needs based upon an initial written and continuing		
	assessment of the patient's needs with input, as		
	necessary, from health professionals involved in the		
	care of the patient.		
	Patients in the facility have been diagnosed as having		
	urinary tract infections, staphylococcal infections,		
	and scabies within the past five months (May through		
	September 1985). However, there is no indication that		
	the facility has taken any actions to monitor, inves-		
	tigate, control or prevent the recurrence of these		
	infections.		

e of Evaluator: Barbara Lee, R.N.
Dana Hall, R.S.

ature of Evaluator: Barbara Lee, R.N.
Dana Hall

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature

Name

Title

CITATION 1424 NOTICE SUPPLEMENT

[illegible] or Citation Number(s) [illegible]
92H-036-07[illegible]
92H-036-07[illegible]

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	For example: At least five (5) patients had urinary tract infections during a one month period (8/14/85 - 9/20/85). Three (3) of these patients had prior urinary tract infections within a four month period (Patients A, B and C) and one (1) patient had suffered four previous urinary tract infections between 12/10/84 and 8/19/85 (Patient D).		
	In a review of discharge records, four (4) patient (E, F, G, H) had discharge diagnoses of urinary tract infections in a two week period (5/14/85 through 6/3/85). Two (2) patients (I and J) were discharged within two days of each other in September 1985 (9/23 and 9/25) with diagnoses of urosepsis.		
	In all cases, patient care plans did not reflect the problem of recurrent urinary tract infections in these patients. Furthermore, the infection control committee did not address the high incidences of urinary tract infections nor did it investigate possible causes in order to institute corrective measures.		
	During the survey it was found that three (3) patients had staphylococcal coagulasepositive infections that occurred within two weeks of each other (8/21, 8/27 and 9/9/85). Unusual occurrence reports on Patients K (8/21/85) and L (9/9/85) were received by the Department but the facility did not report Patient		

Name of Evaluator Barbara Lee, R.N.
Dana Hall, R.S.

Signature of Evaluator Barbara Lee, RN
Dana Hall

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice

Signature

Name

Title

N 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s) 92H-086-070
92H-086-071
92H-086-072

m is used as a Supplement to the Section 1421 Notice (HS 816). When the violations cannot all be listed on the notice, this form is
additional pages

ection	Class and Nature of Violations	Penalty Assessment	Deadline For Compliance
	M's (3.27.85) staphylococcal infection. Failure		
	to do so, and to realize the significance of three		
	staphylococcal infections within two weeks, again		
	resulted in no action being taken by the infection		
	control committee to identify areas of cross con-		
	tamination, poor aseptic techniques and poor hand-		
	washing by the staff. Furthermore, two (2) of the		
	three (3) patients (Patients K and L) were being		
	treated with medication (Erythromycin) that culture		
	and sensitivity tests indicated staphylococcal coa-		
	gulase positive bacteria were resistant to.		
	In addition to the urinary and staphylococcal infec-		
	tions, the facility has had at least three different		
	occasions in the last five months where patients have		
	had scabies. Patient N on 5/2/85, Patients O and P		
	on 8/29/85 and Patient Q on 9/23/85. There was no		
	indication that the facility's infection control com-		
	mittee had made recommendations or implemented any		
	actions to resolve the reoccurrence of the problem.		
	FAILURE OF THE FACILITY TO MONITOR, INVESTIGATE, AND		
	IMPLEMENT MEASURES TO CONTROL RECURRENT INFECTIONS		
	IN THE FACILITY THROUGH THE EFFECTIVE USE OF INFECTION		
	CONTROL COMMITTEE AND CONTINUING ASSESSMENT OF PATIENTS		
	BY ITS NURSING STAFF HAS A DIRECT RELATIONSHIP TO THE		
	HEALTH AND SAFETY OF ALL PATIENTS IN THE FACILITY.		

Evaluator Barbara Lee, R.N.
Dana Hall, R.S.

re of Evaluator Barbara Lee, RN
Dana Hall

Without admitting guilt, I hereby acknowledge receipt of this Citation Notice
Signature
Name
Title

(5/85)

N 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s) 92H-086-070
92H-086-071
92H-086-072

m is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is
additional pages.

ection	Class and Nature of Violations	Penalty Assessment	Deadline For Compliance
	M's (8/27/85) stapnylococcal infection. Failure		
	to do so, and to realize the significance of three		
	staphylococcal infections within two weeks, again		
	resulted in no action being taken by the infection		
	control committee to identify areas of cross con-		
	tamination, poor aseptic techniques and poor hand-		
	washing by the staff. Furthermore, two (2) of the		
	three (3) patients (Patients K and L) were being		
	treated with medication (Erythromycin) that culture		
	and sensitivity tests indicated staphylococcal coa-		
	gulase positive bacteria were resistant to.		
	In addition to the urinary and staphylococcal infec-		
	tions, the facility has had at least three different		
	occasions in the last five months where patients have		
	had scabies. Patient N on 5/2/85, Patients O and P		
	on 8/29/85 and Patient Q on 9/23/85. There was no		
	indication that the facility's infection control com-		
	mittee had made recommendations or implemented any		
	actions to resolve the reoccurrence of the problem.		
	FAILURE OF THE FACILITY TO MONITOR, INVESTIGATE, AND		
	IMPLEMENT MEASURES TO CONTROL RECURRENT INFECTIONS		
	IN THE FACILITY THROUGH THE EFFECTIVE USE OF INFECTION		
	CONTROL COMMITTEE AND CONTINUING ASSESSMENT OF PATIENTS		
	BY ITS NURSING STAFF HAS A DIRECT RELATIONSHIP TO THE		
	HEALTH AND SAFETY OF ALL PATIENTS IN THE FACILITY.		

f Evaluator Barbara Lee, R.N.
Dana Hall, R.S.

re of Evaluator Barbara Lee RN
Dana Hall

Without admitting guilt, I hereby acknowledge receipt of
Citation Notice
Signature
Name
Title

SECTION 1421 NOTICE SUPPLEMENT

Violation or Citation Number(s): 92[illegible]6-07[illegible]
9[illegible]H-036-07
92H-086-072

This form is used as a Supplement to the Section 1421 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline For Compliance
924-036-072	Class "B" Citation - MEDICATIONS		10-15-85
Title 22, CAC			
Sec. 72313(a) (2)	Medications and treatments shall be administered as prescribed.		
Sec. 72315(f) (7)	Each patient shall be given care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include carrying out of physician's orders for treatment of decubitus ulcers.		
	For Example: The September 1985 treatment sheets showed no documentation to indicate that three (3) patients received their treatments for decubiti on the 11 p.m. to 7 a.m. shift as ordered. (Patients A B and C).		
	Treatments for decubiti were documented as done on two (2) patients, but direct observations by Surveyor A indicated treatments were not being done. Patient D did not have Opsite as ordered to his back on 9/30/85 at 10 a.m.. Patient E had orders for a "tub bath 2 x's week with 2 oz. of Betadine" but this was observed not being done during the survey. The designated shower/tub room on Station I appeared in disuse and was instead being used as extra storage space.		
	Patient F had a one time dose of Lasix IM ordered for 9/29/85, but it was not given until 9/29/85 when the		

Name of Evaluator: Barbara Lee, R.N.
Dana Hall, R.S.

Signature of Evaluator: Barbara Lee, RN
Dana Hall

Without admission will I hereby acknowledge receipt of the Citation ?
Signature
Name
Title

SECTION 1424 NOTICE SUPPLEMENT

Violation or Citation Number(s) 92 [illegible]
[illegible] 086-[illegible]
92M-086-[illegible]

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form used for additional pages

Section	Class and Nature of Violations	Penalty Assessment	Deadline For Compliance
	licensed staff discovered it had not been administered		
	the previous day.		
	FAILURE TO ADMINISTER MEDICATIONS AND TREATMENTS AS		
	PRESCRIBED HAS A DIRECT AND IMMEDIATE RELATIONSHIP		
	TO THE HEALTH AND SAFETY OF PATIENTS A THROUGH F AS		
	WELL AS ALL PATIENTS IN THE FACILITY.		

Name of Evaluator Barbara Lee, R.N.
~~Dana Hall, R.S.~~

Signature of Evaluator Barbara Lee, RN
Dana Hall

Without admitting guilt, I hereby acknowledge receipt of the Citation !

Signature

Name

Title

HS 816 A (5/85)

Page 7 of 7 Page/s

[COMMITTEE STAFF NOTE: The following documents pertain to an incident of falsification of a nursing home patient's charts, which took place during an inspection of the nursing home by officials representing the California State Health Department. During the inspection officials' lunch break, an employee of the nursing home altered records to make it appear that the patient's care needs had been fully assessed and responded to by the facility. The discrepancies were noticed and legal action ensued.]

OFFICE OF THE DISTRICT ATTORNEY
COUNTY OF LOS ANGELES
BUREAU OF SPECIAL OPERATIONS
SPECIAL CRIMES DIVISION
NURSING HOME & DEPENDENT CARE SECTION
HALL OF RECORDS
320 WEST TEMPLE STREET STE 780
LOS ANGELES, CALIFORNIA 90012
(213) 974- 5981

IRA REINER, DISTRICT ATTORNEY

PHILIP H. WYNN, DIRECTOR
SPECIAL OPERATIONS

April 1, 1986

Ralph Lopez, Chief
Health Facilities Division
Department of Health Services
313 North Figueroa Street,. Room 317
Los Angeles, California 90012

Dear Mr. Lopez:

Re PEOPLE v. CONVALESCENT HOSPITAL ET AL M2900925

The Los Angeles County Department of Health Services, Health Facilities Division first brought this case to the attention of the District Attorney's Office, Nursing Home and Dependent Care Section, on June 4, 1985. After initial discussion the case was referred back to the Division for supplemental investigation. A criminal complaint against the facility, the licensee, nurses and was filed in the South Bay Judicial District on August 21, 1985, eleven months after the initial investigation giving rise to the cause of action. The Health Facilities Division conducted an additional inspection of Convalescent Hospital on August 26, 1985. No serious deficiencies were noted as a result of that inspection.

Motions to dismiss for pre-complaint delay were filed by all defendants. After extensive negotiations with all defense counsel a disposition was reached under the following terms and conditions:

1. Convalescent Hospital will enter a plea of no contest to three counts;
2. By stipulation Convalescent Hospital will agree to be sentenced under terms of statutes effective March, 1985, thereby increasing their liability from a maximum of $1,000 per count to $2,500 per count;
3 Convalescent Hospital will pay a fine of $5,000 plus penalty assessment for a total of $8,500 on two counts, one count being suspended;
4. The period of probation will terminate upon full payment of the fine and penalty assessment;

5. The corporate officers of Convalescent Hospital will be credited with one day in County Jail as a result of time spent in custody when arrested;

6. Defendant will enter an open plea of no contest to a violation of Penal Code Section 470.5, Falsification of a medical record with the intent to defraud;

7. Remaining counts to be dismissed against remaining defendants.

The above disposition reflects a compromise on the legal and factual issues surrounding the eleven month pre-complaint delay. Furthermore, the nursing home is exposing itself by stipulation to a greater financial liability than required by applicable law. The disposition is also reflective of the fact that the nursing home was found in substantial compliance with applicable regulations after the August, 1985 inspection. The disposition as outlined above occurred on March 19, 1986, in Division 3 of the South Bay Judicial District.

Very truly yours,

IRA REINER
District Attorney

By Leland B. Harris

LELAND B. HARRIS, Deputy In Charge
Nursing Home and Dependent Care Section

jo

Dist. Atty Referral

DEPARTMENT OF HEALTH SERVICES
Health Facilities Division

September 6, 1985

TO: Park Williams

FROM: Jerry Schoettal G. S.

RE: CONVALESCENT HOSPITAL

On 7/19/85, was interviewed at Care

was given her Miranda rights before the interview and she signed the Acknowledgement and Waiver of rights. (see attached copy)

On 7/22/85 at Center, Carrie Bays and myself met with when given his Miranda rights, stated that he did not want to talk to us without an attorney.

At that point he was informed that he or his attorney could call us for an interview at a subsequent time.

ACKNOWLEDGEMENT & WAIVER OF RIGHTS

1. You have the right to remain silent.
2. Anything you say can and will be used against you in a court of law.
3. You have a right to speak with an attorney before questioning and to have him present during any questioning.
4. If you cannot afford an attorney, one will be appointed for you without charge before any questioning.

Do you understand the rights that have been explained to you?

Do you want an attorney or not?

Are you willing to talk about this matter or not?

Signed____

Witnessed

Date 7/19/85 Time 10:32 A.M

DEPARTMENT OF HEALTH SERVICES
Health Facilities Division
ESU

TO: Dave Childress, Supervisor
ESU

FROM: Carrie Bays, Surveyor II CB
ESU

DATE: October 15, 1985

FACILITY: Convalescent Hospital

Torrance, CA

SUBJECT: RESULTS OF INTERVIEW WITH , R.N.
FORMER EMPLOYEE

On 07/19/85 at 10:32 a.m., Gerard Schoettel and I went to Care Center and asked to speak with A female identified herself to Mr. Schoettel and me as We proceeded to a private room and asked Ms. :

- Was she formerly employed at Convalescent Hospital?
- Could we get her permission to speak with her regarding her having been at Convalescent?

Ms. was informed she had the right not to talk with us if she did not wish to do so. Ms. said she would talk with us. Mr. Schoettel informed her he would need to inform her of her rights if she did talk with us. Mr. Schoettel informed Ms. of her rights; she then signed an "Acknowledgement and Waiver of Rights" - which was witnessed by us on 7/19/85. (A copy is attached.)

We asked Ms. if we could tape record our conversation with her. Ms. did not wish for her conversation with us to be tape recorded.

Ms. was showed the following three documents from the Convalescent Hospital patient record of :

Document #1 - 9/19/84 Decubitus Report labeled "Before Lunch".
Document #2 - 8/07/84 Decubitus Report labeled "After Lunch".
Document #3 - 8/03/84 Decubitus Report labeled "9/26/84".

Ms. stated:

Document #1 and #2 were not the same documents. Document #1 was for 9/19/84 and Document # 2 was for 8/7/84.

She was present in the facility during the September survey. She was not asked about these two Decubitus Reports - Documents #1 and #2.

P. 1 of 2 Pages

Memo to Dave Childress
Re: Convalescent Hospital
October 15, 1985
Page 2

Document #2 was the admission note. She did not know about Document #1.

The writing appearing on Document #2 was the writing of , R.N..

She did not know whose writing appeared on Document #1.

, Treatment Nurse, wrote the information above the progress note on Document #2.

The writing on Document #1 appeared to be the writing of the new treatment nurse, but she was not sure.

She added the following to the progress note in Document #3: "L hip size 3.5" x 2.5" stage IV + skin reddened around sacral area size 3" x 3" stage 4 around, C.Q.".

It is 's writing beside the patient body diagram on Document #3. She did not know the meaning of the question marks on this sheet.

She did not know whose writing appeared on the upper left shoulder of the patient body diagram.

Document #2 and Document #3 are the same forms. Document #3 is a photocopy of Document #2.

P.2 of 2 Pages

ē Documentz #1 BEFORE LUNCH

9-19-84

DECUBITUS REPORT

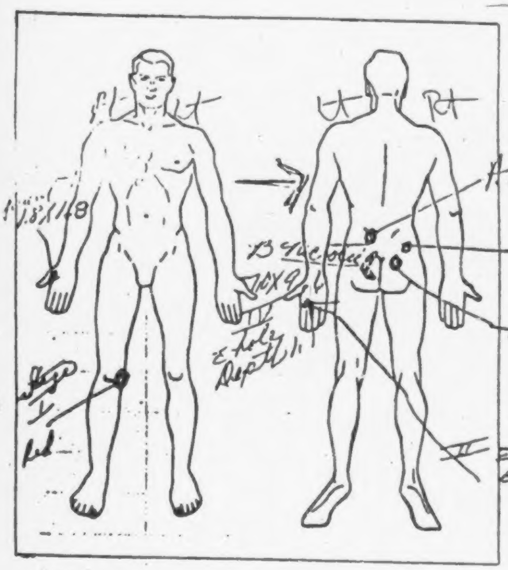
ADMITTING DIAGNOSIS: ______ SEX: M ☐ F ☒ AGE: ______ RACE: ___

AMBULATORY: ______ SEMI-AMBULATORY: ______ CHAIR-RIDDEN: ______ BEDRIDDEN: ______

DATE DECUBITUS NOTED: ______

INDICATE ON DIAGRAM: ______

PRESSURE AREA: ______



A IV ē drainage
2.1X1.2

TREATMENT: ~~Stage IV~~
D 2.1X1.7 ē drainage

C ē drainage ~~purulent~~
6.2X4.4 Stage IV

II ē scant
bleeding 1.9X2.2

PROGRESS NOTES: NOTE RE DECUBITUS SITE ______ DATE 9/19/84

STAGE I II III IV DATE DISC ______ DATE M.D. NOTIFIED ______

SIZE ______ DEPTH COLOR ______

CHARACTER ESCHAR PUS FOUL ODOR GRANULATING CLEAN DRY

DRAINAGE DESCRIBE ______ CULTURE RESULTS ______

TREATMENT ______

PROGRESS ______

SIGNED ______

SIGNATURE: ______

(Progress Notes continued on back)

NAME: ______ DOCTOR: 6

Document #2 AFTER LUNCH

DECUBITUS REPORT

E: 8-3-84

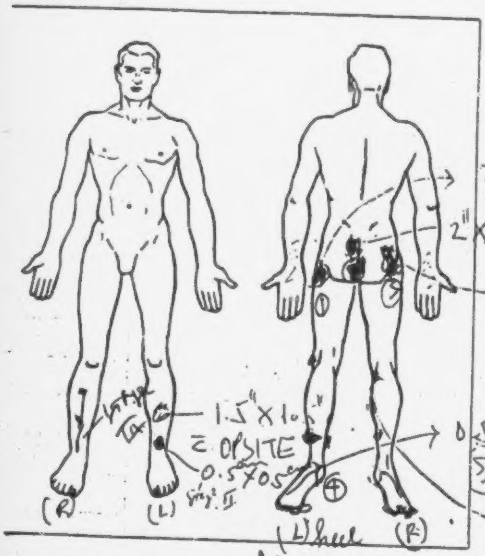
TING DIAGNOSIS: ______ SEX: M ☐ F ☒ AGE: 74 RACE: ______

MBULATORY: ______ SEMI-AMBULATORY: ______ CHAIR-RIDDEN: ______ BEDRIDDEN: ✓

DATE DECUBITUS NOTED: 8-3-84

INDICATE ON DIAGRAM: ______

PRESSURE AREA: ______



3.5" x 2.5" NECROTIC AREA.

2" X 2"

TREATMENT:

S/THREE

2" X 2" S/FOUR

c̄ MULTI ABRASIONS TO BOTH HANDS AND ARMS BUT HAS OP/SITE

0.5" ~~x 0.5"~~

S/THREE

4" x 4" S/FOUR

PROGRESS NOTES: 8-3-84 Admitted c̄ above decub. (L) buttock measures 2"x2" stage III. Surrounding skin area appears red. ø odor c̄ approx. 1/2 cm depth. ø necrosis. Slight serous drainage. (L) heel measures 0.5 x 0.5" stage III. ø necrosis; ø odor. (L) hip size 3.5"x2.5" stage IV + skin redding. Rectal area size 3" x 3" stage IV around[illegible]

The (L) leg has skin tear - irregular. ø drainage; reddened; measures 1.5 x 1.5 ø depth. Also ō multiple abrasions to both hands + arms c̄ opsite intact. Skin very fragile & dry; usually bleeds upon deep contact.

SIGNATURE: ______

(Progress Notes continued on back)

ME: ______ DOCTOR : ② ADM. # ______ ROOM: ______ BED: ______

Back of Documents #3

Original information

1) 2"x2" . S/Three

2 c̄ Multi. Abrasions to both hands and
arms but has Op/site

3) 0.5" x 0.5" S/Three

4) 1.5" x 1.5" c̄ Opsite

Document #3 7/26/84

DECUBITUS REPORT

DATE: [redacted] -84

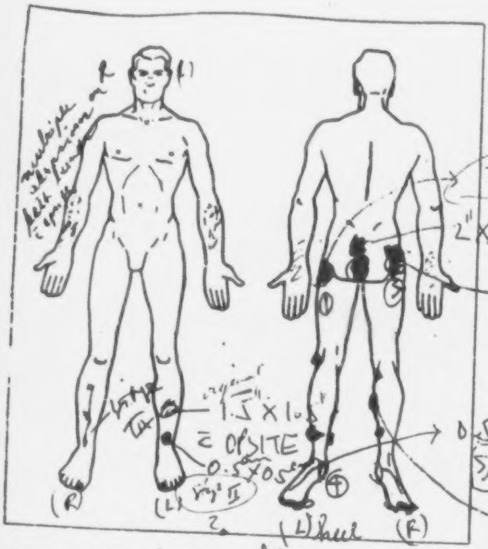
ADMITTING DIAGNOSIS: [redacted] SEX: M ☐ F ☒ AGE: 79 RACE:

AMBULATORY: SEMI-AMBULATORY: CHAIR-RIDDEN: BEDRIDDEN: ✓

DATE DECUBITUS NOTED: 8-3-84

INDICATE ON DIAGRAM:

PRESSURE AREA:



2.

3.5" X 2.5" NECROTIC (SIXTY)

2"X2" TREATMENT:

S/THREE

?

2" X 2" S/FOUR

c̄ MULTI ABRASIONS TO BOTH HANDS AND ARMS BUT HAS OP/SITE

0.5" X 0.5"

S/THREE

4 X 4 S/FOUR ?

PROGRESS NOTES: 8-3-84 Admitted c̄ acute decub. (L) buttock measures 2"x2" Stage ~~III~~ IV Surrounding skin area appears red. ⊘ odor c̄ approx. 1/2 cm depth. ⊘ necrosis. Slight serous drainage. (L) heel measures 0.5 X 0.5" stage III ⊘ necrosis, ⊘ odor. Ⓛ hip size 3.5"x2.5" stage IV, + skin reddened sacral area size 3"x3" stage IV wound. The (L) leg has skin tear - irregular, ⊘ drainage, reddened measures 1.5 X 1.5 ⊘ depth. Also c̄ multiple abrasions to both hands + arms c̄ opsite intact. Skin very fragile & dry; usually bleeds upon deep contact.

SIGNATURE

(Progress Notes continued on back)

NAME: [redacted]

DOCTOR : ADM. # ROOM: BED:

[The following documents consist of indictments against nursing homes for serious violations of health and safety laws. The indictments were sought and obtained by specialists within the offices of State Attorneys General from New York and Colorado during 1986. Final disposition of these cases was not known at time of publication.]

Duane Woodard
Attorney General
Charles B. Howe
Chief Deputy Attorney General
Richard H. Forman
Solicitor General

The State of Colorado
DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL

STATE SERVICES BUILDING
1525 Sherman Street
Denver, Colorado 80203
Phone 866-3611 & 866-3621

May 12, 1986

David Schulke, Esq.
Special Committee on Aging
Room G-33
Dicksen Building
Washington, D.C. 20510

FEDERAL EXPRESS
619448830

Dear Mr. Schulke:

Here are the indictments. Glad we could help.

Sincerely,

Morgan Rumler

MORGAN RUMLER, Esq.
Assistant Attorney General
Medicaid Fraud Control Unit

MR/pt

Enclosures

DISTRICT COURT, CITY AND COUNTY OF DENVER, COLORADO

Case No. 85CV0002

INDICTMENT

THE PEOPLE OF THE STATE OF COLORADO,

v.

INC.,

Defendant.

COUNT ONE

RECKLESS ENDANGERMENT;
Section 18-3-208 C.R.S.(1978
Rep. Vol.)
Class 3 Misdemeanor.

STATE OF COLORADO)
) ss.
City & County of Denver)

Of the 1985-1986 Term of the Denver District Court, in the year 1986, the 1985-1986 State Grand Jurors chosen, selected, and sworn in and for the State of Colorado, upon their oaths, present the following in the name and by the authority of the People of the State of Colorado:

COUNT ONE

On or about August 16, 18, 19, 20, 21 and 22 of 1985 in the County of Denver, State of Colorado, Inc. did unlawfully commit the offense of Reckless Endangerment by recklessly engaging in conduct which created a substantial risk of serious bodily injury to contrary to the provisions of Section 18-3-208 C.R.S (1978, Rep. Vol.), a class 3 misdemeanor and against the peace and dignity of the People of the State of Colorado.

This offense was committed in the following manner:

From 1974 until August 23, 1985 , d.o.b. February 17, 1889, was a resident of a nursing home located at , in the City and County of Denver, State of Colorado.

Beginning in April 1984 and continuing through August 1985 a Georgia corporation, Inc. was the corporation hired by the owner of the nursing home, , to manage all aspects of the nursing home which was known as " ".

In April 1985 a new administrator was hired at . The nursing home administrator functioned as the principal executive officer at . It was the administrator's responsibility to administer and supervise all aspects of the operation of . Her duties included, but were not limited to, directing the supervisory staff; developing and implementing policies for recruitment, staffing, and training of personnel; evaluating and implementing annual budgets; developing and implementing standards of employee conduct while on duty, working hours and rates of pay; planning and implementing policies for purchasing supplies, food and other necessities of operation; developing and implementing billings and collection services, and general accounting procedures; and determining that care of patients was maintained. The administrator at during August 1985 was a high managerial agent of Inc.. This was her first job as the sole administrator of a nursing home.

The administrator reported to and consulted with the regional director in Denver for Inc.. The regional director was in that position from approximately September 1, 1984 to September 1, 1985. The regional director was to provide guidance and leadership to the management staffs of the six nursing home facilities Inc. managed and operated in the Denver area, and to serve as a liaison to Inc.'s home office in Georgia. The regional director during August 1985, was a high managerial agent of Inc.. This was his first job as a regional director of nursing homes.

In May 1985, a member of nursing staff was promoted to the position of director of nursing. She reported to the nursing home administrator. The duties of the director of nursing included, but were not limited to, guiding and assisting the professional staff in the development of a nursing care plan to meet the needs of each patient; carrying on continuous evaluation of nursing care and recommending staffing patterns to meet the needs of each patient; assigning responsibility and delegating authority; making final selection of nursing personnel; participating in the development of patient care policies; assisting in the evaluation of the effectiveness of policies and procedures and suggesting need for revision in the interest of more effective service; cooperating with the administration and other departments in maintaining a safe and sanitary environment; preparing recommendations for the budgets; and acting in an administrative capacity in the administrator's absence. The director of nursing at during August 1985 was a high managerial agent of Inc.. This was her first job as a director of nursing.

In August 1985, Bertha was afflicted with a condition known as organic brain syndrome, a chronic condition due to her advanced age which means she was unable to interact with her environment in any meaningful fashion. She was chronically bedridden and unable to communicate, except for such basic actions as withdrawing her limbs from painful stimuli and responding with her eyes to loud stimuli. Bertha was a total care patient.

In August 1985 Bertha also had arteriosclerotic peripheral vascular disease of longstanding duration in both of her feet. Arteriosclerotic peripheral vascular disease refers to hardening of the arteries so that there is very little blood circulation to the extremities.

In August 1985, Bertha had a medical history of decubitus ulcers on her feet, especially her right foot, which had become infected several times, in addition to long-standing osteomyelitis, or infection of the bones near the decubiti.

Bertha primary physician had given orders as early as December 1984, that 's feet were to be soaked in a Betadine solution. Betadine is an anti-infective agent. Betadine soaks to 's feet were ordered by her primary physician numerous times from December 1984 to August 23, 1985. Depending on the condition of the decubiti, the soaks would be ordered, then ordered to be discontinued, then ordered again. Again depending on the condition of the decubiti, the soaks were ordered to be given as needed, or sometimes once a day, sometimes twice a day, sometimes three times a day. Ms. wore protective booties instead of shoes.

It was the responsibility of the nursing staff on the second floor where Ms. 's room was located to make sure that Ms. received the Betadine treatments as ordered.

Ms. was also one of about ten patients on a ward of thirty patients who had been listed as needing special attention because they had decubitus ulcers in need of special care. The decubiti for which Ms. was listed were those on her coccyx. Consequently, in August, 1985 Ms. was put to bed other than at mealtimes to remove the pressure of sitting from her coccyx. She was to receive treatments with a heat lamp and an anti-infectant solution for these decubiti also.

On March 26, 1985, Bertha was admitted to Hospital when her foot decubiti became particularly inflamed. She was discharged on April 5, 1985 with the infection controlled, although the decubiti were still present. Amputation of her right foot was discussed by her primary physician and other physicians at Hospital at the time, but the decision was made to treat Ms. conservatively first, that is, without surgery.

On July 10, 1985, Ms. 's primary physician decreased the number of Betadine soaks to Ms. 's right foot from twice a day, previously ordered on May 20, 1985, to once a day. The soaks were to be given during the 7 a.m. to 3 p.m. nursing shift.

On August 16, 18, 19, 20, 21, and 22 of 1985 Betadine soaks were not given to Bertha feet. On the evening of August 22, 1985, maggots were found infesting the decubiti on Ms. 's right foot.

There were three open decubiti on Ms. 's right foot: one at the outside base of the great toe which had not been invaded by maggots; one at the outside base of the smallest, or the fifth toe, which was infested with maggots too numerous to count and some of which were found underneath the bone; and one beneath the fourth and fifth toes which was also maggot infested. Cleaning the ulcers and removing the maggots took two people an hour and a half to complete.

Ms. was then transported to the emergency room at Hospital where her decubitus ulcers were further treated, with one maggot found remaining in the ulcer at the base of the fifth toe. She was admitted to the hospital from the emergency room.

The decubiti near the fifth toe were infected, as was the bone. Some of the tissue was dead, and the bone was exposed. When the decubiti failed to respond to further conservative treatment, on September 9, 1985 the fifth toe of Bertha 's right foot was amputated. When the condition of her right foot continued to deteriorate, on November 2, 1985 her entire right foot was amputated below the knee. Ms. 's condition then improved. She was discharged to a nursing home in Lakewood, Colorado on November 22, 1985.

Maggots are fly larvae. A common variety of fly in the Denver region is the blow fly. The blow fly is attracted to odoriferous infected wounds where it lays eggs which hatch into maggots usually within 24 hours. The maggots feed on dead tissue.

Renovation of the windows was being done at during August 1985. Screens were off at least half of the windows in the building, and many windows were open due to the summer heat.

There is a substantial risk of decubitus ulcers, "bedsores", occurring in nursing home patients. They are caused by the constant pressure of bones against another firm surface.

That Bertha had decubitus ulcers on her right foot complicated by poor blood circulation to her feet, and that the decubiti should be monitored carefully so that Ms. 's physician could be notified promptly of any deterioration, and that Ms. 's feet were to be given Betadine soaks daily were known to the director of nursing in August 1985. This information was also known by the charge nurse, that is, the supervisory nurse for the second floor on the 7 a.m. to 3 p.m. shift on August 19, 20 and 21 of 1985. It was also known by the treatment nurse on August 19, 20, 21, and 22 of 1985. The "treatment nurse" who was an L.P.N., gives treatments such as Ms. 's Betadine soaks. That the Betadine soaks were to be given was known also by the second floor charge nurse on the 7 a.m. to 3 p.m. shift on August 16, 17 and 18, 1985.

Yet on August 16, 18, 19, 20, 21, and 22 of 1985, Betadine soaks were not given to Bertha 's right foot. The charge nurse was unable to get to the soak on August 16, but she did do it the next day. She is not sure why the soak was not done on August 18. The treatment nurse did not do it on August 19, 20, 21 and 22 because Ms. was in bed to relieve the pressure on her coccyx and the treatment nurse felt she could not give the foot soaks with Ms. in bed.

The lack of observation and treatment of decubiti on the right foot of Bertha on August 16, 18, 19, 20, 21, and 22, 1985 created a substantial risk: of infection in the ulcers and systemic infection throughout Ms.

's body; of the creation of gangrene, or dead tissue, in the ulcer to the point of maggot infestation; of amputation of the foot; and of death during surgery. Ms. was a surgical risk because she was 96 years old in August 1985, had arteriosclerotic peripheral vascular disease, and due to her organic brain syndrome she would have been unable to cooperate in her post operative recovery.

The nurses at were unable to treat Ms. 's foot because they were overworked due to a lack of staff on the second floor sufficient to provide the patients with adequate care. During June, July and August of 1985, began to rely heavily on nursing pools to supply staff. This interrupted the continuity of patient care.

The director of nursing had to function as both the second floor charge nurse and as director of nursing many times. On August 22, 1985, the L.P.N., "treatment nurse" was in charge on the second floor during the 7 a.m. to 3 p.m. shift, but since she was not an R.N. and the director of nursing was, the director of nursing was also responsible for the second floor even though she was working elsewhere in the building.

The director of nursing could not do both jobs adequately. She did not have time to do the treatments herself or to even look at Ms. 's feet, nor to review the care being provided by the nursing staff. She did not even have the time to function adequately as the director of nursing. Much of her time was spent trying to hire staff and in arranging for "pool people" to fill in. Then she was too busy to make sure adequate orientation was being given to the people being sent from the pools.

In June 1985 a staff L.P.N. was promoted from charge nurse to inservice director. This was her first job as inservice director. The inservice director is responsible for orienting new employees to their jobs and providing training sessions on patient care.

The inservice director was to spend three days a week doing inservice work, and two days as charge nurse on the intermediate care floor. During the three days she was inservice director she was also supposed to keep track of the intermediate care floor activities. The inservice director was too busy to orient new employees and those coming from the nursing pools to their jobs.

There were not enough aides and orderlies on staff to provide adequate care to the patients without the L.P.N.'s and R.N.'s helping with the aides' and orderlies' work, thereby decreasing the time the L.P.N.'s and R.N.'s had to spend on their own work. Being overworked, low wages and the "point system", which was used to fire employees who had accumulated too many demerits, were among the factors contributing to the lack of staff.

The reason Bertha 's feet were not monitored properly and given the Betadine soaks was because due to inadequate staffing the staff on duty did not have time to provide such care or to fulfill their supervisory duties to make sure the care was given.

The director of nursing during August 1985, a high managerial agent of Inc., engaged in and knowingly tolerated within the scope of her employment and in behalf of the corporation inadequate staffing to provide for patient care at .

The nursing home administrator during August 1985, a high managerial agent of Inc. engaged in and knowingly tolerated within the scope of her employment and in behalf of the corporation inadequate staffing to provide for patient care at .

The regional director in Denver during August 1985, a high managerial agent of Inc., engaged in and knowingly tolerated within the scope of his employment and in behalf of the corporation inadequate staffing to provide for patient care at

The director of nursing, the administrator and the regional director were inexperienced in their jobs and were unable to affect corporate level policy changes to cure the staffing problem.

The director of nursing consciously disregarded a substantial and unjustifiable risk that patients would suffer injury because of neglect resulting from inadequate staffing.

The nursing home administrator consciously disregarded a substantial and unjustifiable risk that patients would suffer injury because of neglect resulting from inadequate staffing.

The regional director of Denver consciously disregarded a substantial and unjustifiable risk that patients would suffer injury because of neglect resulting from inadequate staffing.

AS TO COUNT ONE, A TRUE BILL: Mary M. Gutschalk 2-21-86

Foreman

NO TRUE BILL: ______________________________

Foreman

I, Mary Gutschalk, the foreman of the state grand jury do hereby swear and affirm that the true bill returned in this indictment and presented herein by the state grand jury was arrived at after deliberation and with the assent of at least nine members of the state grand jury.

Mary M. Gutschalk 2-21-86

Mary Gutschalk

Subscribed and sworn to before me in the County of Denver, State of Colorado, this 21st day of February, 1986.

A. Otto Ulrich

Notary Public

My Commission Expires: 7-15-88

DUANE WOODARD
Attorney General
State of Colorado

Morgan Rumler

MORGAN RUMLER #9165
Assistant Attorney General
Enforcement Section

1525 Sherman St., 3rd Floor
Denver, CO 80203
866-5668

LIST OF WITNESSES

[COMMITTEE STAFF NOTE: Names of witnesses and corporate entitites have been omitted for brevity. The full text of this indictment is available from the Attorney General, State of Colorado.]

The Court orders this indictment returned and venue designated in Denver County, State of Colorado, in the Second Judicial District

BY THE COURT:

Clifton A. Flowers

Chief Judge
Second Judicial District 2-21-86
State of Colorado

STATE OF NEW YORK
DEPUTY ATTORNEY GENERAL
FOR MEDICAID FRAUD CONTROL
270 Broadway, New York, N. Y. 10007
(212) 587-5389

EDWARD J. KURIANSKY
Deputy Attorney General

PETER M. BLOCH
Special Assistant
Attorney General-in-Charge

June 10, 1986

Mr. David Schulke
Special Committee on Aging
G-33 Dirksen Building
Washington, D.C. 20510

Dear David:

As we discussed yesterday, enclosed are copies of the indictments of the Home for the Aged , Nursing Home, and various employees of these homes for illegally soliciting admissions contributions from families of Medicaid patients. I am also enclosing copies of the civil complaint and preliminary injunction in the case which involves private pay contracts.

Please feel free to call me if you have any questions or need further information.

Very truly yours,

Beatrice A. Close
Deputy Director-Patient Abuse

BAC:lbt

Enclosures

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX
--X

PEOPLE OF THE STATE OF NEW YORK,

-against-

Defendants.
--X

IND. NO.
897/86

COUNT ONE:

VIOLATING SECTION 2805-f(4)(b)(i)
OF THE PUBLIC HEALTH LAW

A TRUE BILL

Vera V. Snellings
FOREPERSON, GRAND JURY

Edward J. Kuriansky
EDWARD J. KURIANSKY
DEPUTY ATTORNEY GENERAL
STATE OF NEW YORK
270 Broadway
New York, NY 10007

COUNT ONE:

THE GRAND JURY OF THE COUNTY OF BRONX, by this indictment, accuses the defendants of the crime of violating Section 2805-f(4)(b)(i) of the Public Health Law as follows:

The defendants

. INC., in the County of Bronx, from on or about June 24 to July 10, 1985, knowingly and willfully charged, solicited, accepted and received from a person acting on behalf of a recipient and applicant for assistance under title eleven of article five of the social services law (hereinafter "Medicaid Program") in addition to amounts otherwise required to be paid pursuant to the Medicaid Program and to title XVIII of the social security act (the "Medicare Program"), a gift, money, donation and other consideration, as a precondition, express and implied, to admitting and expediting the admission of such recipient and applicant to a hospital and residential health care facility, the cost of the services being paid for, in whole or in part, pursuant to the Medicaid Program, in that:

the defendant, , the Director of Development, and the defendant , INC., through high managerial agents of the corporation, acting within the scope of their employment and on behalf of the corporation, solicited and accepted $20,000 from a person known to them as Samuel S as a precondition, express and implied, to admitting and expediting the admission of Medicaid recipient Muriel S into the INC., a residential health care facility.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

PEOPLE OF THE STATE OF NEW YORK,

-against-

Defendants.

INDICTMENT

VIOLATING SECTION 2805-f(4)(b)(i) OF THE PUBLIC HEALTH LAW (1 COUNT)

EDWARD J. KURIANSKY
DEPUTY ATTORNEY GENERAL
STATE OF NEW YORK

FILED 2/26/86

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS
--X

PEOPLE OF THE STATE OF NEW YORK,

-against-

X ,X , and
NURSING HOME, INC.,

Defendants.

--X

INDICTMENT NO.
1499/86
SUPERSEDING IND. NO.
579/86

COUNTS

VIOLATING SECTION 2805-f(4)(b)(i)
OF THE PUBLIC HEALTH LAW (2 COUNTS)

-Two counts against defendants and Nursing Home, Inc.

-One count against defendant

CONSPIRACY IN THE FIFTH DEGREE (1 COUNT)
-One count against defendants , and Nursing Home, Inc.

A TRUE BILL

FOREPERSON, GRAND JURY

Edward J. Kuriansky
EDWARD J. KURIANSKY
DEPUTY ATTORNEY GENERAL
STATE OF NEW YORK
270 Broadway
New York, NY 10007

COUNT ONE

THE GRAND JURY OF THE COUNTY OF KINGS, by this indictment, accuse the defendants of the crime of violating Section 2805-f(4)(b)(i) of the Public Health Law as follows:

The defendants , and NURSING HOME, INC., in the County of Kings, from on or about June 18 to July 11, 1985, knowingly and willfully charged, solicited, accepted and received from a person acting on behalf of a recipient and applicant for assistance under title eleven of article five of the social services law (hereinafter "Medicaid Program") in addition to amounts otherwise required to be paid pursuant to the Medicaid Program and to title XVIII of the social security act (the "Medicare Program"), a gift, money, donation and other consideration, as a precondition, express and implied, to admitting and expediting the admission of such recipient and applicant to a hospital and residential health care facility, the cost of the services being paid for, in whole or in part, pursuant to the Medicaid Program, in that:

the defendant, , the Director of Development, and the defendant, , the Executive Director of defendant NURSING HOME, INC., and the defendant NURSING HOME, INC., through high managerial agents of the corporation, acting within the scope of their employment and on behalf of the corporation, solicited and accepted a pledge in the amount of $25,000 and received $12,500 from a person known to them as Samuel S as a precondition, express and implied, to admitting and expediting the admission of Medicaid recipient Muriel S into the NURSING HOME, INC., a residential health care facility.

COUNT TWO

THE GRAND JURY OF THE COUNTY OF KINGS, by this indictment, accuse the defendants of the crime of violating Section 2805-f(4)(b)(i) of the Public Health Law as follows:

The defendants, , and , INC., in the County of Kings, from on or about April 29, 1985 to May 11, 1985, knowingly and willfully charged, solicited, accepted and received from a person acting on behalf of a recipient and applicant for assistance under title eleven of article five of the social services law (hereinafter "Medicaid Program") in addition to amounts otherwise required to be paid pursuant to the Medicaid Program and to title XVIII of the social security act (the "Medicare Program"), a gift, money, donation and other consideration, as a precondition, express and implied, to admitting and expediting the admission of such recipient and applicant to a hospital and residential health care facility, the cost of the services being paid for, in whole or in part, pursuant to the Medicaid Program, in that:

the defendant, , the Director of Development, and the defendant INC., through high managerial agents of the corporation, acting within the scope of their employment and on behalf of the corporation, solicited a pledge in the amount of $10,000 from a person known to the grand jury, as a precondition, express and implied, to admitting and expediting the admission of a Medicaid recipient into the , INC., a residential health care facility.

COUNT THREE

THE GRAND JURY OF THE COUNTY OF KINGS, by this indictment, accuse the defendant of the crime of CONSPIRACY IN THE FIFTH DEGREE (in violation of Section 105.05 of the Penal Law) committed as follows:

The defendants, and , INC., in the County of Kings, from on or about June 18, 1985 through on or about July 11, 1985, with intent that conduct constituting a felony in violation of Public Health Law Section 2805-f(4)(b)(i) be performed, agreed with each other and with one or more other persons to engage in and cause the performance of such conduct, in that:

At all times during the conspiracy, the defendant, , was the Director of Development and the defendant, , was the Executive Director of , INC., and the defendant , INC. was a residential health care facility licensed by the State of New York.

The defendant , the defendant , and the defendant , INC. agreed with each other and with one or more other persons to solicit and accept a pledge in the amount of $25,000 and to receive $12,500 from a person known to them as Samuel S as a precondition, express and implied, to admitting and expediting the admission of Medicaid recipient Muriel S into the , INC.

OVERT ACTS

In furtherance of the conspiracy, and to effect the unlawful objects thereof, the defendants, in the County of Kings, committed the following overt acts, among others:

1. On or about June 18, 1985, had a conversation with , the Executive Director of

2. On or about June 19, 1985, had a telephone conversation with "Samuel S " in which told "Samuel S " that he had spoken with and that had said that if "Samuel S " was still willing and interested in making the $25,000 donation his mother would be at the head of the list.

3. On or about June 20, 1985, had a telephone conversation with "Samuel S ' in which indicated and stated to "Samuel S " that his mother would be the next patient admitted to

4. On or about July 11, 1985, had a conversation with "Samuel S ' during which conversation accepted and received a check from "Samuel S ', signed by "Samuel S " and payable to the in the amount of $12,500.

received
4-21-86

STATE OF NEW YORK
COUNTY OF MONROE   SUPREME COURT

THE PEOPLE OF THE STATE OF NEW YORK,
by Robert Abrams, Attorney General
of the State of New York,

Plaintiff,

-vs-

NURSING HOME, INC.,
a New York corporation;

,

Defendants.

VERIFIED
COMPLAINT

Index No. 4528/86

The People of the State of New York, by Attorney General Robert Abrams, allege:

INTRODUCTION

1. This action is commenced by the Attorney General to enjoin violations of New York's Nursing Home Patient's Bill of Rights and certain deceptive and unlawful business practices by Nursing Home, Inc. (' ") and its owners, . The Attorney General also seeks a declaratory judgment, restitution and damages for injured consumers and the imposition of civil penalties under General Business Law Article 22-A.

2. The conduct sought to be enjoined is (1) 's practice of misrepresenting its duty to accept Medicaid payments and its right to discharge Medicaid recipients; and (2) its requirement that prospective residents or their sponsors guarantee private payment of daily charges for nursing home care for a specified period of time.

PARTIES

3. Attorney General Robert Abrams brings this action on behalf of the People of the State of New York to protect the welfare of its citizens.

4. Nursing Home, Inc. is a New York corporation formed pursuant to the New York Business Corporation Law. It operates a proprietary nursing home and maintains its principal offices at , Monroe County, New York.

5. is President of Nursing Home, Inc. and owns one-half of its outstanding stock. He is also employed as Administrator of Nursing Home and directs its daily financial and administrative operations. He resides at , , Monroe County, New York.

6. is Secretary-Treasurer of Nursing Home, Inc. and owns one-half of its outstanding stock. She is employed as Director of Nurses at Nursing Home. She resides at , , Monroe County, New York.

JURISDICTION AND VENUE

7. The Court has jurisdiction over this action by virtue of Executive Law §63, subd. 12, which permits the Attorney General to apply for relief thereunder in Supreme Court whenever he determines that a person is engaging in repeated fraudulent or illegal acts or otherwise demonstrates persistent fraud or illegality in carrying on a business. Jurisdiction to render a declaratory judgment is provided by Civil Practice Law and Rules §3001.

8. Venue is placed in Monroe County, New York, based on the residence of the defendants.

FACTS

9. Nursing Home, owned and operated by the defendants, is a skilled nursing facility authorized by the New York State Department of Health to operate with 72 beds. The rate charged by for basic services in a semi-private room is $85 per day.

10. has, for many years, contracted with New York State to provide care to residents who apply for and are found eligible to receive "Medicaid" payments under Article 5, Title 11 of the New York Social Services Law.

11. is required by state regulations (18 NYCRR §540.7[a][8]) to accept payment at the rate established by the State Department of Health in full satisfaction of charges assessed for basic services or supplies furnished to recipients of Medicaid assistance. The base rate which currently receives is $72.36 per day.

12. is prohibited by state regulations (10 NYCRR §414.14[a][5]) and federal regulations (42 CFR §442.311[c]) from transferring or discharging a resident without his or her consent except for (1) medical reasons; (2) the welfare of the resident or other residents of the nursing home; or (3) nonpayment of amounts due to the nursing home.

13. is not permitted to transfer or discharge residents against their will solely because their care is being paid for through the Medicaid program at rates lower than those charged to residents not eligible for Medicaid assistance.

14. is prohibited by state regulations (10 NYCRR §415.1[i]) from discriminating against any resident in retention or care because the cost of the resident's care is wholly or partly paid for through Medicaid assistance.

15. is required by New York's Nursing Home Patients Bill of Rights (Public Health Law §2803-c, subd.3[a]) and federal regulations (42 CFR §442.311[d][1]) to encourage and assist its residents in the fullest possible exercise of their rights, including the right to apply for and receive Medicaid assistance in meeting the cost of nursing home care, without fear of reprisal or a reduction in the quality of care received.

16. Upon initial inquiry by a prospective resident concerning the terms under which admission is obtained, provides a packet of informational materials which includes a booklet entitled "Resident Policies - Financial Agreement and Policies - Residents Rights." A copy of this booklet is attached hereto as Exhibit A.

17. This policy statement contains various provisions concerning the rights of residents to remain at . Concerning 's agreement to furnish room, board and nursing care, the following language appears at page 4: "DURATION OF AGREEMENT - Either party may terminate this agreement on 10 days written notice."

18. On page 7 of the booklet, under the heading "MEDICAID," the following provision appears: "Since our ability to care for welfare residents depends largely upon the reimbursement allowed by the State of New York, the nursing home will not commit itself to care for those residents for an indefinite period. If termination of care is necessary, the family will be given ten days written notice of this termination."

19. The policy statement contains additional provisions concerning a resident's right to apply Medicaid benefits to the cost of care at . On page 6, under the heading "MEDICAID," the following provisions appear: "1. Medicaid is a Welfare Program. does not accept welfare as a payment source except under special agreement. 2. The management reserves the right to move any cases covered under welfare to different accomodations within the nursing home than those occupied while otherwise financed."

20. The policy statement also provides, at page 7, that once has given the 10 day written notice of its intention to terminate the care of a resident who has obtained Medicaid assistance, "the family will be billed at a rate to be determined by the nursing home until the resident is removed."

21. Upon information and belief, routinely requires prospective residents or their sponsors to execute a Financial Agreement in which they guarantee that they will pay the private rate for a specified number of months. A copy of such an agreement is attached hereto as Exhibit B. Information contained in the document which would identify the resident who executed it has been redacted.

22. Upon information and belief, residents and their sponsors have, pursuant to the aforementioned agreements and guarantees, paid for care at at the private rate for periods during which the resident receiving care would have been eligible to receive Medicaid assistance to meet the cost of such care.

FIRST CAUSE OF ACTION

(violation of Patients' Bill of Rights)

23. The defendants' actions alleged herein constitute an infringement of the residents' right to make independent personal decisions and to obtain knowledge of available choices regarding the methods of paying for the care provided by , in violation of Public Health Law §2803-c, subd. 3(a) and Title 42, Code of Federal Regulations §442.311 (d)(1).

24. The defendants have failed to comply with their duty to encourage and assist their residents in the fullest possible exercise of their rights to apply for and receive Medicaid assistance to pay for the cost of their care, in violation of Public Health Law §2803-c, subd. 3(a) and Title 42, Code of Federal Regulations §442.311 (d)(1).

25. Such conduct constitutes repeated and persistent illegal conduct in the carrying on of a business in violation of Executive Law §63, subd. 12.

SECOND CAUSE OF ACTION

(deceptive trade practices)

26. The defendants regularly publish and provide to applicants for admission, their sponsors and current residents a policy statement which falsely states or would lead to the mistaken belief that (1) has the right to terminate at will its agreement to provide a resident with room, board and nursing services; (2) is not legally required to accept payments under the Medicaid program for a resident's care; (3) has the right to

terminate its agreement to provide room, board and nursing services solely because a resident has obtained Medicaid assistance to pay for his or her care; and (4) once has given 10 days written notice of its election to terminate the care of a resident receiving Medicaid assistance, the resident's family will be financially responsible for subsequent care at a rate unilaterally set by .

27. Because is required by state regulations (18 NYCRR §540.7(a)(8)) to accept payments at the rates established by the State Department of Health in full satisfaction of amounts owed for basic services provided to Medicaid-eligible residents, contracts guaranteeing private payment of higher rates for such services are contrary to public policy, illegal, unenforceable and void.

28. The defendants, knowing that such agreements are illegal and unenforceable, have repeatedly and persistently required residents or their sponsors to execute financial agreements whereby the resident or sponsor agrees to pay 's charges at the "private" rate for a specified period of time.

29. Such conduct misleads residents concerning their rights and obligations and constitutes deceptive acts and practices in the conduct of a business or in furnishing a service in violation of General Business Law §349, subd. (a).

THIRD CAUSE OF ACTION

(Fraudulent business conduct)

30. The defendants regularly publish and provide to applicants for admission, their sponsors and current residents a policy statement which falsely states or would lead to the mistaken belief that (1) has the right to

terminate at will its agreement to provide a resident with room, board and nursing services; (2) is not legally required to accept payments under the Medicaid program for a resident's care; (3) has the right to terminate its agreement to provide room, board and nursing services solely because a resident has obtained Medicaid assistance to pay for his or her care; and (4) once has given 10 days written notice of its election to terminate the care of a resident receiving Medicaid assistance, the resident's family will be financially responsible for subsequent care at a rate unilaterally set by

31. Because is required by state regulations (18 NYCRR §540.7[a][8]) to accept payments at the rates established by the State Department of Health in full satisfaction of amounts owed for basic services provided to Medicaid-eligible residents, contracts guaranteeing private payment of higher rates for such services are contrary to public policy illegal, unenforceable and void.

32. The defendants, knowing that such agreements are illegal and unenforceable, have repeatedly and persistently required residents or their sponsors to execute financial agreements whereby the resident or sponsor agrees to pay 's charges at the "private" rate for a specified period of time.

33. Such conduct misleads residents concerning their rights and obligations and constitutes engaging in repeated fraudulent acts in carrying on a business in violation of Executive Law §63, subd. 12.

FOURTH CAUSE OF ACTION

(unconscionable contract)

34. It is the public policy of New York State, set forth in Social Services Law §363, to "promote maximum public awareness of the availability of, and procedure for obtaining, ...[Medicaid] assistance, and to facilitate the application for, and the provision of such medical assistance."

35. The portion of s Admission Agreement which requires the resident or sponsor to guarantee a specified period of payment at "private" rates is, in intent and effect, an agreement to refrain from seeking Medicaid assistance for that period of time regardless of need.

36. Such a provision, which attempts to obtain from the prospective resident or sponsor a waiver of their right to seek Medicaid assistance, as a condition of admission to , is directly contrary to the public policy of this State and is unconscionable.

37. The defendants' repeated and persistent requirement that prospective residents or their sponsors execute such agreements as a condition of admission to constitutes persistent fraud in the carrying on of a business in violation of Executive Law §63, subd. 12.

RELIEF

WHEREFORE, the People of the State of New York, by Attorney General Robert Abrams, request judgment as follows:

1. declaring the actions of the defendants to be unlawful;

2. declaring any and all agreements signed by residents or their sponsors guaranteeing private payment of the cost of care for a specified period of time to be against public policy, unconscionable, unenforceable and void;

3. permanently enjoining the defendants from engaging in conduct found by the Court to be deceptive, fraudulent or illegal;

4. directing the defendants to assist and encourage present and future residents of Nursing Home in the fullest exercise of their right to obtain Medicaid assistance to pay for the cost of care provided by the defendants;

5. directing the defendants to pay restitution and damages to individuals who have been injured by the defendants' deceptive, fraudulent and illegal conduct;

6. directing the defendants, and each of them, to pay a civil penalty in the amount of Five Hundred Dollars ($500.00) for each separate violation of General Business Law Article 22-A, as provided in General Business Law §350-c;

7. directing the defendants, and each of them, to pay costs in this action in the amount of Two Thousand Dollars ($2,000.00) to the Attorney General; and

8. granting such other and further relief as to the Court shall seem just and proper.

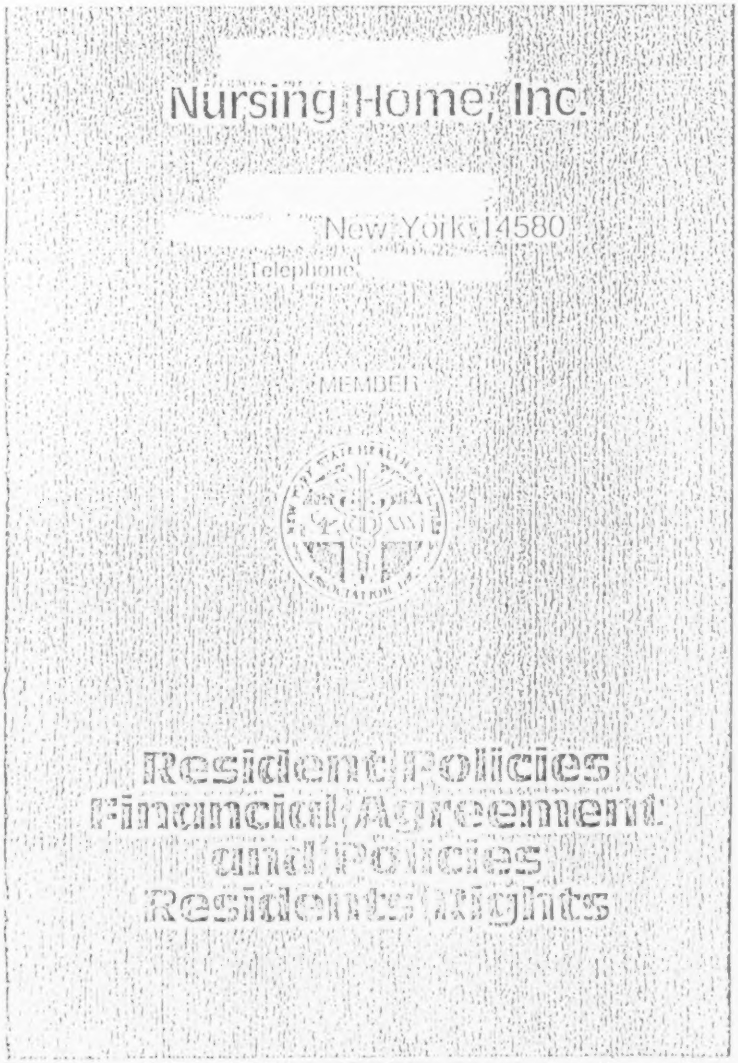
Dated: April 17, 1986

ROBERT ABRAMS
Attorney General of the
State of New York

BY: ______________________
K. WADE EATON
Assistant Attorney General
NYS Department of Law
144 Exchange Boulevard
Rochester, New York 14614
Tele.: (716) 546-7430

Attorney for plaintiff

[COMMITTEE STAFF NOTE: The contents of Exhibit A are not included for brevity. The Court Order and Preliminary Injunction following this document contain portions of Exhibit A that were found by the Court to be questionable and unenforceable.]



[redacted]
Nursing Home, Inc.

[redacted]
[redacted] New York 14580
Telephone [redacted]

MEMBER

Resident Policies
Financial Agreement
and Policies
Residents Rights

Exhibit A

/order -- MA -- kwe/cad/4/29/86

STATE OF NEW YORK
COUNTY OF MONROE   SUPREME COURT

THE PEOPLE OF THE STATE OF NEW YORK,
by Robert Abrams, Attorney General
of the State of New York,

Plaintiff,

-vs-

NURSING HOME, INC.,
a New York corporation;

Defendants.

ORDER

Index No. 4528/86

Upon the Verified Complaint herein and the stipulation of the parties dated May 12, 1986, it is hereby

ORDERED that the defendants be and they are hereby enjoined, pending entry of a final judgment herein, from soliciting, requiring or accepting any agreement by present or prospective residents of the Nursing Home, or by any other person acting on behalf of or for the benefit of any present or prospective resident, in which such person agrees, contracts or guarantees to provide private payment for a specified period of time to the defendants, or any of them, of the cost of care and services provided or to be provided to any present or prospective resident; it is further

ORDERED that the defendants be and they are hereby enjoined, pending entry of a final judgment in this action and as long as there exists a Medicaid provider agreement in effect between Nursing Home, Inc. and the New York State Department of Social Services, from making any written or oral statements to any present or prospective patient or sponsor, which state or reasonably imply that:

(a) the defendants have an unqualified, unilateral right to terminate the Admission Agreement;

(b) the defendants do not or are not required to accept Medicaid payments for the cost of the continuation of care provided to a resident of Nursing Home who qualifies for Medicaid assistance;

/order -- MA -- kwe/cad/4/29/86

(c) the defendants have the right to terminate their agreement to provide room, board and nursing services because of a resident's application for or receipt of Medicaid assistance; or

(d) the family of a resident receiving Medicaid assistance may be financially responsible for the cost of room, board or nursing services provided by the defendants; it is further

ORDERED that the defendants shall, pending entry of a final judgment in this matter, excise, remove or mask the statements presently contained on pages 4, 6 and 7 of the pamphlet entitled "Resident Policies, Financial Agreement and Policies, Patients Rights" which are underlined on copies of those pages constituting Attachment 1 hereto.

Signed this 15 day of May, 1986 at Rochester, New York.

ENTER:

Justice of the Supreme Court

STANDARD ADMISSION WAIVER

1. The management of this home has agreed to exercise such reasonable care toward this person as his or her known condition may require; however, this home is in no sense an insurer of his or her safety or welfare and assumes no liability as such.

2. The management of this home will not be responsible for any valuables or money left in the possession of this person while he or she is a resident of this home.

DURATION OF AGREEMENT

Either party may terminate this agreement on 10 days written notice. Otherwise it will remain in effect until a different agreement is executed. However, this does not mean that the resident will be forced to remain in the nursing home against his or her will for any length of time.

State and Federal laws prohibit discrimination based on Race, Creed, Color, National Origin or Sex.

Attachment 1

4. All residents or their responsible party shall be given a statement of the nursing home charges prior to admission.

FINANCIAL POLICY

1. All indebtedness of the resident to the nursing home shall be paid by the resident or his responsible party as these charges are due. Accounts shall be kept and statements issued on a 14 day or 28 day basis, whichever is desired by the person making payment.

2. Interest charges will be assessed against accounts that are overdue.

3. Services rendered at the nursing home shall be charged on a full day's basis only, including the last day or portion thereof.

4. The billing week begins on Wednesday and runs through Tuesday of the following week. Charges for room, board and nursing services are payable in advance. Charges for personal items and services are payable upon receipt of the statement.

5. Charges for the services of a barber or beautician shall be in addition to the normal room rate.

6. Minimum charge for new admissions will be on the basis of 14 days room charges.

7. We request that all payments be made by check or bank draft.

RESERVATIONS

Room reservations are taken if a resident is to be admitted at a later date. For a room to be reserved a deposit is required and the rate during the time the room is unoccupied shall be the daily rate.

MEDICARE

The home has been recognized as a Medicare Provider.

INSURANCE

Investigate all health coverage a resident has with the individual companies. Under certain contracts Blue Cross covers a portion of the bill, as does Kodak's Major Medical, A.A.R.P., Mutual of Omaha and several others.

MEDICAID

1. Medicaid is a Welfare Program. __________ does not accept welfare as a payment source except under special agreement.

2. The management reserves the right to move any cases covered under welfare to different accomodations within the nursing home than those occupied while otherwise financed.

3. Since our ability to care for welfare residents depends largely upon the reimbursement allowed by the State of New York, the nursing home will not commit itself to care for those residents for an indefinite period. If termination of care is necessary, the family will be given ten days written notice of this termination. Upon the expiration of this period the family will be billed at a rate determined by the nursing home until the patient is removed.

4. Supplemental payments to the welfare rate to the nursing home by residents or responsible parties are not permitted under the laws of the State of New York.

5. Questions concerning welfare can best be answered by the welfare office of Monroe County.

TIPPING

No gratuities may be given to any employees of the nursing home. Employees have been so instructed. Your cooperation is appreciated.

REFUNDS

Refunds shall be made on the basis of unused days of care. The refund shall be made promptly and in full less any outstanding charges. Under no circumstances are refunds made on room deposits, the first 14 days after admission or partial days.

COMPLAINTS

All complaints concerning the operation and services in the nursing home should be made to the management or the nursing supervisor. Telephone any time problems of this nature arise. We cannot take the appropriate action unless we are informed.

VISITING HOURS

1. Visiting hours in resident rooms shall be restricted to the hours between 2:00 and 8:00 p.m.

2. Visiting in the solarium is permitted at any time the resident can be up and dressed.

3. In private rooms the visiting hours are not restricted unless such visiting interferes with the care of the residents.

4. The number of visitors any one resident may have at any one time shall be consistent with the resident's condition, the well being of other residents, and the space available in the room.

5. Private visiting rooms are available, but a reservation is necessary since these areas are used for special conferences.

'stip -- MA -- kwe/cad/4/29/86

STATE OF NEW YORK
COUNTY OF MONROE   SUPREME COURT

THE PEOPLE OF THE STATE OF NEW YORK,
by Robert Abrams, Attorney General
of the State of New York,

Plaintiff,

-vs-

NURSING HOME, INC.,
a New York corporation;

Defendants.

STIPULATION

Index No. 4528/86

IT IS HEREBY STIPULATED AND AGREED by and between the parties hereto that the Order attached hereto, preliminarily enjoining the defendants from engaging in certain conduct alleged by the Attorney General to be unlawful, be executed by a justice of the Supreme Court and entered by the Clerk of the Court, to be of the same force and effect as an Order actively contested and adjudicated; provided, however, that nothing herein shall constitute or be deemed an admission by any of the defendants of the truth of any of the allegations contained in the Verified Complaint, or an admission of any civil or criminal wrongdoing on the part of any defendant, or a waiver of any defense which may be hereafter raised, except that the defendants do hereby admit proper service upon each of them of the Summons and Verified Complaint herein on April 17, 1986.

Dated: May 12, 1986

Kenneth V. Kouwe, Esq.
Attorney for defendants
Room 600
65 Broad Street
Rochester, New York 14614

K. Wade Eaton
Assistant Attorney General
Attorney for plaintiff
144 Exchange Boulevard
Rochester, New York 14614

[The following documents pertain to changes in staffing at a rural nursing home after a change in the facility's ownership.]

CARE CENTER

RURAL ROUTE

PHONE

TO: Director of Nurses

Personal and Confidential

FROM: Administrator

SUBJECT: Staffing

DATE: March 17, 1982

Based on my recent visit with representatives, there will probably be a cut in staffing in nursing from that previously authorized by The following information is for your use only and should be used along with any additional information we received from in the future concerning staffing.

We will not hire any new employees. You have already implemented via discussion with me a swing shift person working 5-1. This will serve to reduce hours in staffing on 11-7 shift.

Initial estimates indicate authorizes about 1.75 hours per patient day on ICF Care and 2 hours per patient day on SNF Care. I would estimate we would have a total minimum mumber of hours per day in the following range: 215 hours per day to 236 hours per day. (Total hours could be higher.) This includes all nurses and aides on all shifts. Possible suggestions to keep in mind include: working one aide on 3-11 only 4 hours per day on both wings; reducing nurses on 3-11 to 1 on each wing; reducing total aides on various areas of building ie 7-3 shift ICF wing down to 5 aides per day instead of 6; reducing 11-7 aides on ICF wing to 1 that starts at 11 at night. Remember no definite information is available. No changes will be made until we have further information. The above are intended as possible variations to consider.

Strong emphasis needs to be maintained by you on a positive approach to any changes we may consider and that employees need to have confidence that "patient care" will continue to remain at a high level and will not suffer.

As I learn more I will discuss it in more detail with you. No changes are to be made below current staffing unless we discuss it in detail.

[Excerpt of letter regarding staffing changes at subject nursing home.]

ADMINISTRATORS ([STATE])
March 22, 1982
Page 2

(This should be the approximate way you are staffing now.)	New Staffing
5 licensed nurses x 8 = 40.00 hours	3 licensed nurses x 8 = 24.00 hours
13 A&O x 7.5 = 97.50 hours	11 A&O x 7.5 = 82.50 hours
*40.00 hours - RN & L.P.N. 97.50 hours - A&O 137.50 total hours	24.00 hours - L.P.N. 82.50 hours - A&O 106.50 total hours
137.50 ÷ 60 beds = 2.30 nurses per patient per day	106.50 ÷ 60 = 1.78 nurses per patient per day

* This does not include your D.O.N. Her hours would bring you up to about 2.34.

So, essentially what I am saying is do not go over 137.50 hours per day on your skilled wing and do not go over 106.50 hours per day on your ICF wing for a total of 244.00 hours per day. (Depending on your calculator and rounding off, you could come up with 140.40 skilled hours and 106.80 hours ICF or 247.20 total.)

This is not optional, but mandatory. This new staffing pattern should be completely implemented no later than April 23, 1982.

Incidentally, this will cause approximately $3,000.00 positive cash flow on your facility per month (except).

If you have any questions, please let me know.

cc: Vice-President, Operations
Region 2 Nurse

CARE CENTER

RURAL ROUTE

PHONE

TO: Director of Nurses

Personal and Confidential

FROM: Administrator

SUBJECT: Nursing Department Staff Levels under

DATE: April 22, 1982

This is intended as a follow up to our conversation concerning staffing in nursing under . We have been allowed a ratio of approximately 1.53 hours per patient day maximum.

This breaks down to the following number of individuals working in nursing providing patient care per our estimated census.

Census	Hours Allowed	Approximate Ratio
116	183 per day	1.58
111	175.50 per day	1.58
110	168 per day	1.53

The above hours are based on the following number of people working per day. You are free to schedule them on any shift and to use a full time position as a part time person to give an extra set of hands on a shift.

Census	Total hours Per Day allowed	RN/LPN Nurses	Aides/Orderlies
110	168	6@8hrs=48 total	16@7.5hrs=120 total
111	175.5	6@8 hrs=48 total	17@7.5ea=127.50 total
116	183	6@8hrs=48 total	18@7.5hrs=135 total

The above does not include the hours for the RN position we discussed.

If you have questions, please contact me. I'll work with you in every way I can. Once you have determined what you want to staff on each shift according to the above information let me know.

This needs to be implemented no later than 5-1-82.

April 25, 1982

Mrs , R.N.
Director of Nursing
Ctr.

Dear Mrs.

Due to the cutting in staff, I don't feel I can do my job to my satisfaction

So I will resign as of May 13, 1982.

I've enjoyed working with all the great people at Ctr.

Sincerely yours,
, LPN

CARE CENTER

RURAL ROUTE

TO:
Administrator

FROM: RN
Director of Nursing

SUBJECT: Increased staffing needs

DATE: July 8, 1982

The B wing 7-3 shift is in dire need of help. We have 55 patients on this wing. Out of this number 15 are skilled with the possibility of adding another skilled care tomorrow. The remaining patients are all heavy lifting, hard to care for ICF patients. At present is is pushing hard for four aides to meet all their daily needs. The licensed nurses are very busy with tube feedings, other treatments and medications and supervision of floor staff.

We do not have any extra people hired. Therefore if someone is absent it creates an imposition on the regular help to work over or give up their off days. This is creating a problem with overtime.

I request you consider this very carefully. I would like to add another nursing assistanty by July 15, 1982. This would give us time to evaluate and determine if the census is going to stay up. I feel it will increase by then if we do not loose any more residents. According to my records we now have in house 111.

Your request is approved. You need to make plans accordingly.

7-9-82

[August 30, 1982]

Mr.
Administrator
Care Center

Dear Mr.

It is with deepest regret that I feel I have become forced, due to a continual negative working relationship with you, to resign my position as Director of Nursing at Care Center.

It is against my better judgment as a professional nurse to continue employment at this facility when I feel and believe that you have repeatedly, by your disruptive behavior, been allowed to affect the quality of patient care that the nurses diligently try to administer.

I personally and professionally feel that I have not been given the fair chance and opportunity to meet the challenges of this position without unfair stress or pressure by you.

I strongly feel that your personality and inability to work with others has definitely had a detrimental affect in the quality of patient care. The major point that should be recognized is that the manner in which an administrator criticizes, and not necessarily the comment itself, may likely determine whether or not he is a disruptive force within a facility.

The two years I have invested in this facility have been a, needless to say, grave learning experience. I feel that I have functioned well beyond what should have been expected of me under the stress, pressure and personal attacks which have been made obvious to all concerned. I have truly tried to make decisions in my present position in the best interest of this facility But due to the smooth working relationships which I have repeatedly been unable to develop with you, the nursing staff as well as myself, have not been able to function to their maximum productivity level, thereby resulting in errors.

I do want to express my heartfelt best wishes for the future of this facility. I think if the truly negative factors that are presently in existence are eliminated there is a bright future for Care Center. I have, for approximately 25 years, served the people of this county with all the love and compassion that should be characteristic of every nurse.

In conclusion, I feel that you have been a disruptive force within this facility; that you have difficulty in establishing satisfactory relationships with people; that you fail to obtain facts, thereby arriving at premature judgments; that you are easily influenced and lack the strength of your convictions; that you have acted in a way which has been detrimental to the nurses and staff; and, that your actions, in general, have had an adverse affect upon the smooth working relationships so necessary for the provision of health care.

This letter serves as my resignation effective [immediately] .

I am sorry that the situation has been allowed to result in this decision.

Respectfully submitted,

, R.N.
Director of Nursing

CARE CENTER

RURAL ROUTE

TO:

Director of Nursing

FROM:

Administrator

SUBJECT: Nursing Staffing

DATE: October 4, 1982

Over the past few weeks I've been keenly aware of your problems concerning adequate staffing on the wings due to call in absences. A quick review of your current number of staff indicates we do not have a proper number of aides and nurses on payroll to meet our needs under a 4 - 2 schedule.

As you know this type schedule requires 1 full time relief person for every 2 positions. Using our present staff goals of 19 aides per day we would need an additional 9 people on full time status to meet our needs. This would give us a total of 28 full time people. We currently have only 27 full time people according to your latest information supplied to the office. We have 3 part time aides, 2 of which have limited availability. Thus we are also short in this area too.

Please consider this as authorization to re-evaluate your staff needs and hire the proper staff to insure coverage for the facility.

In the area of nurses, continure to try and hire 1 RN, to replace Mrs. , and 1 LPN to work 11-7 shift relief.

Mrs. is our only part time LPN and Mrs. is our only part time RN relief.

Remember under our current set up new potential aides must be hired in co-ordination with the Employment Office. See me for details.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

[EXCERPT OF INSPECTION REPORT]

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

Care Center

(X1) PROV./CER NUMBER

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED
03/21-22/83

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Page 2			
	Plan of Care 249.12(b)(3)(i)	T-79	Plan of care for residents requiring physical therapy will be done. (This will be monitored by Administrator, DON, and nurses) Nurses will report irregularities.	4-12-83
T 78	No documentation of physical therapy can be found since November, 1982. Physical Therapy continues to be ordered by physician. 249.12(a)(3)(i)	T-94	All past due deliquent physicians will make a visit to correct lacking documentation and improve on past documentation. (Adequate visitation, orders signed, and medications reviews will be done on a timely basis).	4-12-83
T 79	No updated and ongoing plan of care for physical therapy was found since November, 1982. Physical Therapy continues to be ordered by physician. 249.12(b)(3)(i)			
	XII. PHYSICIAN SERVICES 249.12(b)(6)	T-95	Physician orders will be followed by nursing service. Intense work has been implemented to improve documentation, and medication problems via nurse consultant, Pharmacy Consultant, and Administration areas.	6-1-83
T 94	249.12(b)(6) NOT MET			
T 94	58 of 89 records reviewed revealed physician visits were not documented at least every 60 days. 249.12(b)(6)		Medications will be available at all times. Monitoring of 40 MAR per day beginning 3-30-83, will be done with proper documentation. (On 4-6-83 inservice was given to nursing on documentation etc.).	4-12-83
	XII. HEALTH SERVICES 249.12(a)(9)			
T 95	249.12(a)(9) NOT MET			
T 95	Health services are not being provided			

FORM SSA-2567A (11-79)

Page 2 of 7

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

Care Center

(X1) PROVIDER NUMBER

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED
03/21-22/83

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Page 3 (continued)			
T 95	as needed to each resident as evidenced by (1) Physician orders are not being followed and consistently documented, including: strict intake and output, range of motion exercises, diabetic urine testing, and recorded vital signs. (2) Medications are not available as identified on 24 records and one or more omissions in administration of medication as identified in 41 of 89 charts reviewed. 249.12(a)(9)			
T102	Responsible Staff Members 249.12(a)(9)(ii) NOT MET	T-102	Nursing service organization is being evaluated by nurse consultants to determine necessary changes to make efficient use of staff while correcting problem areas.	5-1-83
T102	Review of work schedules of nursing staff reveals there is not sufficient personnel available at all times to care for the needs of the residents as evidenced by (1) the medication errors and omissions in administration of medications; (2) the number of medications scheduled to be given each shift, i.e.: Day 610, Evening 371, and Nights 42; (3) Physician orders not followed for range of motion exercises, diabetic urine testing, recording of intake and output, and vital signs; (4) With ICF census of 112 residents, including 100 incontinent patients, 112 confused, 11 patients with decubiti, 37 patients to be fed and 95 patients requiring restraints, there is a ratio of 1 Licensed Nurse and 2 Nurse's		Documentation of personnel absenties will be done with appropriate action to correct absences to insure adequate staffing in nursing on all shifts. Reviews on the number of medications are being conducted by the pharmacy consultant and nursing consultant	4-12-83
			MAR Audits of 40 per day being done to assist medications problem.	4-12-83

FORM SSA-2567A

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R0911

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

Care Center

(X1) PROVIDER NUMBER

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________
B. WING ________

(X3) DATE SURVEY COMPLETED
03/21-22/83

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Page 4			
T102	(continued) Aides on the night shift during the past two week period on several occasions. 249.12(a)(9)(ii)			
	XIV. DIETETIC SERVICES 249.12(a)(7)			
	Meals 249.12(a)(7)(i)			
T108	The lunch meal was not served to the residents during the hours it was supposed to be served in accordance with the policy manual on 03-21-83 and 03-22-83. It was 1:00 p.m. before some residents were served. 249.12(a)(7)(i)	T-108	Tray service on the wing will be improved. Dietary Department will insure proper tray order, timed delivery to insure efficient operation. (Review of tray order etc. will be done monthly by FSM, DON and Administrator).	4-12-83
T117	Sanitary Conditions 249.12(a)(7)(vi) NOT MET	T-117	Kitchen will be painted and cleaned.	4-12-83
T117	The kitchen floor has grease and other build-up on it. The walls and ceiling are dirty. 249.12(a)(7)(vi)	T-118	Dietary consultant and nursing will evaluate need for self help devises and document such. Items needed will be provided. Nursing service will monitor and encourage use of same.	5-1-83
T118	Self-Help Devices 249.12(a)(7)(vii) NOT MET			
T118	Individuals in need of self-help devices are not being provided those items in all cases. 249.12(a)(7)(vii)			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72 R0731

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

Care Center

A. BUILDING ____
B. WING ____

DATE SURVEY COMPLETED: 03/21-31/83

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Page 5			
	XV. DRUGS AND BIOLOGICALS 249.12(a)(8)			
T119	Pharmacist 249.12(a)(8)(i) NOT MET	T-119	Internal and external medications will not be stored together. Proper labeling of all items will be done to requirements. (Spot checks and documentation of such will be done) All necessary items will be provided. (Inservice has been provided to the pharmacist by on 4-5-83 and nursing service received a medication inservice on 3-30-83).	4-5-83
T119	External medications such as Cortisporin Ointment, Nitrol Paste, Mytrex Ointment, Selsun Shampoo, etc., are stored with internal medications. Drugs are not properly labeled by the Pharmacist when dispensed in containers not used for unit dose. Numerous medicines were not available including: Lasix, Dilantin, Isordil, Kaon, Apresoline, and Haldol. 249.12(a)(8)(i)			
	Conformance with Physicians' Drug Order 249.12(a)(8)(ii)	T-126	Physician orders will be countersigned in an appropriate manner. Phone orders will be handled via implementation of forms designed for this purpose. Monitoring will be done by Administration, DON, and nurse consultants.	5-1-83
T126	19 of 89 charts reviewed contained one or more orders not countersigned by the physician. 249.12(a)(8)(ii)			
T129	Medication Review 249.12(a)(8)(v) NOT MET	T-129	Inservice in proper monthly review of of medication via pharmacist has been given by on 4-5-83. Improved documentations will be noted. Proper follow up by Administrator will insure future compliance. Documentation of follow-up to problems will be kept by Administrator.	4-12-83
T129	The monthly review of medications does not identify and document numerous medication omissions, medication administration errors and medications not available. 249.12(a)(8)(v)			

FORM SSA 2567A

Page 5 of 7

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72 R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

CareCenter

(X1) PROVIDER NUMBER

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED
03/22-23/83

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Page 6			
	XVI. RESIDENT RECORD SYSTEM 249.12(a)(4)			
	Content 249.12(a)(4)(i)			
T138	Refer to T 94. 249.12(a)(4)(i)(B)	T-138	(see T-94)	
	XVIII. ENVIRONMENT AND SANITATION 249.12(a)(6)	T-153	Paper towel and soap will be installed in all patients bathroom.	5-1-83
	249.12(a)(6)(i)	T-184	Appropriate means of identification will be provided to assist residents in locating their room.	4-12-83
T153	Favorable Environment for Residents 249.12(a)(6)(i) NOT MET			
T153	There are no paper towels or soap available to patients in the bathroom areas. 249.12(a)(6)(i)			
	Facilities for Physically Handicapped 249.12(a)(6)(ix)			
T184	The facility is not providing appropriate means for the blind residents to identify their rooms. 249.12(a)(6)(ix)(5.11)			

FORM SSA 2567A

Page 6 of 7

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72 R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

CareCenter

(X1) PROVIDER NUMBER

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETE
03/21-22/83

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	Page 7			

The Plan of Correction must be returned within ten (10) days. It must include a specific plan for correcting each deficiency and must indicate the date by which each deficiency was or will be corrected.

Gerald G. Pigue
Regional Medical CareAdministrator

RETURN THESE FORMS TO:

Gerald G. Pigue
Medical Quality Assurance
Tennessee Department of Public Health
C2-212 Cordell Hull Building
Nashville, TN 37219-2505

FORM SSA-2567A (11-79)

Page 7 of 7

[COMMITTEE STAFF NOTE: The following inspection reports, pertaining to four federally certified nursing homes in Florida, illustrate the "chronic" or recurring violations that can occur at many facilities, despite regulatory action.]

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

June 14, 1985

Administrator
Nursing Center ["A"]

Dear Ms.

This letter confirms the findings of a Medicare/Medicaid Post-Certification and Licensure deficiency follow-up visit conducted on May 31, 1985 by Nancy Marcum, R.N., representing this office. The resident census on the date of the visit was 94 patients.

The purpose of this visit was to determine the status of correction of the deficiencies which required the issuance of a Statement of Deficiencies and Plan of Correction (HCFA-2567) for Federal programs, and a Classification of Deficiencies for Nursing Home Licensure Requirements (HRS Form 553D), following the survey of April 24-26, 1985.

Attached are your copies of the Post-Certification Revisit Report (HCFA-2567B) listing the Federal program deficiency that had been corrected, and the annotated HRS Form 553D which indicates the status of correction for licensure deficiencies at the time of this visit. It was determined that all deficiencies had been corrected.

These reports will be submitted for distribution to the appropriate agencies and will be made available to the public as required by Florida Statute 400.191 and Public Law 92-603.

If further clarification of this report is needed, please feel free to contact this office.

Sincerely,

Carol E. King
Carol E. King
Senior Human Services
Program Administrator

NM/jp

OFFICE OF LICENSURE & CERTIFICATION• 4000 W. BUFFALO AVENUE• TAMPA, FLORIDA 33614• (813) 272-3440
BOB GRAHAM GOVERNOR

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE & CERTIFICATION
P. O. Box 210
Jacksonville, Florida 32231

CLASSIFICATION OF DEFICIENCIES
FOR NURSING HOME LICENSURE REQUIREMENTS

Facility: Facilities, Inc., d/b/a Nursing Center ["A"]

Date of Visit: April 24, 1985

Street Address, City, State, Zip Code:

Column (1) Contains a listing of deficiencies observed during the survey conducted on April 24, 1985 and regulatory references.
Column (2) classifies the deficiency in accordance with Chapter 400.23 of the Florida Statutes.
Column (3) lists the date by which the deficiency must be corrected.
The licensure law provides for penalties as follows: $1,000 to $5,000 for Class I; $500 to $1,000 for Class II, and $100 to $500 for Class III.
Column (4) is reserved for state agency use and will be used to document the status of corrections on the dates of revisits.

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT STATE AGENCY USE ONLY
	PHYSICIAN SERVICES 10D-29.107			
NH-68 (F-190)	Physicians' orders were not followed in that a medication ordered to be administered on April 23, 1985, had not yet been ordered from the Pharmacy almost 48 hours later.	III	Immediate	NH-68 5/31/85 Corrected NMA

TRR/cc

Provider Representative's Signature

Date May 16, 1985

Page 1 of 1 Pages

HRS Form 663D, Oct 79 (Replaces previous edition)

HRS
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
MEDICAID PROGRAM OFFICE
2255 East Bay Drive, Clearwater, Florida 33546

Date: August 29, 1985

, Administrator
Nursing Center ["A"]

Dear

The attached Facility Evaluation Summary represents the findings of the INSPECTION OF CARE completed on August 9, 1985.

The Summary contains the observations, conclusions, and recommendations of the Medicaid team concerning the adequacy, appropriateness and quality of all services provided in the facility or through other arrangements, and compliance with Federal requirements relating to medical records.

Your facility was found to be in compliance with the Federal and State rules, regulations and policies governing Inspections of Care in skilled nursing facilities and intermediate care facilities with the exception of the following:

☒ Medications & Treatments
☒ Tests & Observations
☒ Plan of Care
☒ Professional Progress Notes
☐ Health Care Services
☐ Social/Activity Services
☒ Certification/Recertification
☐ No Corrective Action Necessary

It is requested that you submit and implement a corrective action plan on the above checked items within 15 days of the exit interview.

Your assistance and cooperation are appreciated. If you have any questions, please contact this office at 813/536-5911.

Sincerely,

Mary Ellen Grose

(Mrs.) Mary Ellen Grose
Senior Human Services Program Manager
Medicaid Program

cc: Office of Medicaid Program Development (2)
Long Term Care Ombudsman Council - District V
, President; Nursing Centers, Inc.

MEG/mlg

DISTRICT FIVE
BOB GRAHAM, GOVERNOR

FACILITY EVALUATION SUMMARY - ["A"] NURSING CENTER - VISITED 8/9/85

MEDICATIONS AND TREATMENTS

(2) - 11 records with aberrations in administration including the following:

- no sites were documented for intramuscular medications including Demerol, Keflin and Menoeid.
- catheter care was incompletely documented.
- no documentation of dressing change with steri-strip change.
- medications were circled with no documentation as to why.
- a "give as needed" Haldol order was not used in May, June or July.
- although resident was repeatedly noted by nursing as being very agitated to the point of throwing dishes.
- incomplete documentation of as needed medications on the p.r.n. cards when initialed on the medication administration record (MAR).
- incomplete documentation of medications on routine schedules, with no reason documented for omission.

FACILITY EVALUATION SUMMARY - ["A"] NURSING CENTER - VISITED 8/9/85

PHYSICIAN/NURSING SERVICES/OTHER PROFESSIONAL SERVICES

(1) - Physician progress notes over 90 days on 1 intermediate record.

- no report of chest x-ray on 1 record - ordered on admission.

- 1 Care Plan did not address resident's ability to ambulate pushing his wheelchair. Problem stated he was wheelchair bound, non-ambulatory.

- 1 Care Plan did not address history of urinary tract infections and current problem with frequency of urination.

- 1 Care Plan needed update for presence of foley catheter.

- 1 Care Plan did not address resident's pacemaker.

(4) - Nursing notes were incomplete regarding documentation of vital signs at the time of falls and for 24 hours afterwards.

- 1 record was missing a monthly summary for July.

- There were instances of inappropriate charting on 2 records of residents who were confused and disoriented and not responsible for their behavior. One example: "This woman is utterly ridiculous, can't reason with her." Another example: "Resident receives excellent skin care, therefore skin is in excellent condition."

- 1 record had only 1 line references to doctor visits for the months of May and June. Contained no reference to status of resident other than monthly summary.

- Nursing notes did not include mode of transportation to and from doctors' offices.

- Monthly summaries did not always address pertinent issues as mental state, activity, skin condition, method of eating, but some did go into aimless detail regarding finger painting with excrement, seeming enjoyment with punching, pinching, pulling nurses' hair and then laughing, etc.

- 1 record recorded fever on 1 shift with no follow-up documentation on the next shift.

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE & CERTIFICATION
P. O. Box 210
Jacksonville, Florida 32231

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS

Facilities, d/b/a

Facility ["B"] Nursing Home Date of Visit July 1-3, 1985

Street Address, City, State, Zip Code

Column (1) Contains a listing of deficiencies observed during the survey conducted on July 1-3, 1985 and regulatory reference.
Column (2) classifies the deficiency in accordance with Chapter 400.23 of the Florida Statutes.
Column (3) lists the date by which the deficiency must be corrected.
The licensure law provides for penalties as follows: $1,000 to $5,000 for Class I; $500 to $1,000 for Class II; and $100 to $500 for Class III.
Column (4) is reserved for state agency use and will be used to document the stage of corrections on the dates of revisits.

(1) DEFICIENCY AND REFERENCE	(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
ADMINISTRATION AND MANAGEMENT 10D-29.104			STATE AGENCY USE ONLY
NH-6 (P-606) A. The latest reconciliation available for Patient Trust Funds was 4/30/85 for the regular account and 3/31/85 for the Deceased Trust Account. Therefore the written account was not maintained on a current basis for each resident.	III	8/5/85	NH-6 A. 11-4-85 Corrected FWR B. 11-4-85 Corrected FWR
(P-75) B. Patients' privacy was being violated. Several patients received treatments with curtains not drawn. One (1) patient was placed on bedpan without curtains being drawn or door closed. Reference: Chapter 400.022 (h) F.S.	III	8/5/85	F-75 1/14/86 Corrected BFD
FWR/cc AUG 01 1985			

Provider Representative's Signature

Date Aug 10/85

CLASSIFICATION OF DEFICIENCIES FOR
NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
NH-39	The surety bond of $10,000.00 was inadequate to cover twice the average monthly balance in active and deceased patients accounts which totaled $13,071.84.	III	8/5/85	STATE AGENCY USE ONLY NH39 11-4-85 Corrected FWR
	PHYSICIANS SERVICES 10D-29.107			
NH-68 (P-189/ P-190)	Physician's orders were not followed as written as evidenced by the following: 1. An original order for a medication was not transcribed to the medication administration sheet and consequently eighteen (18) doses of medication were not given. 2. In two (2) instances, the wrong generic medication was given. 3. In two (2) instances, the wrong dosage of medication was given. 4. One (1) medication was omitted.	III	Immediate	NH-68 8/13/85 Not corrected. NH Physician's orders not followed. Examples include: 1. Nurse administered Trofanil 50mg at 9:45 a.m. instead of 1 p.m. 2. sporadic documentation of vitals when the Doctor ordered specific monitoring. 3. Nurse monitored radial pulse when the Doctor ordered apical readings. NH68 11-4-85 Corrected NMH
	NURSING SERVICES 10D-29.108			
NH-80 (P-135)	The facility did not provide 24-hour nursing services sufficient to meet total nursing needs. The care was not always provided in accordance with the patient care policies. Examples included but were not limited to the following:	III	8/5/85	NH-80 8/13/85 Not corrected. NH Nursing care was not provided to meet total patient needs. Examples include: 1. Intake & output sporadically documented.

NOTIFICATION OF DEFICIENCIES FOR
NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE	(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
1. Intake and output records were sporadically maintained, so that 24-hour fluid balances could not be accurately determined. 2. Suction machines were found dirty and the catheters were uncovered and lying on the floor. 3. Oxygen cannulae were uncovered and found dangling on the floor. 4. Two (2) patients that were on continuous feedings were found with empty bags. 5. Five (5) out of six (6) patients receiving oxygen therapy had no signs on doors alerting visitors and/or staff. 6. There was a prevalent urine odor during most of 3 days. Several patients were checked and found to be incontinent of urine and stool. 7. One (1) patient found unkept and uncomfortable was terminal and was in need of positioning, oxygen sunctioning.			STATE AGENCY USE ONLY 2. There was a prevalent urine odor or 1 wing. 3. Several patients were checked and found to be incontinent. 4. Bedpan was on patient's bedside stand next to breakfast tray. 5. O^2 cannulae found uncovered and lying on floor. 6. Betadine and Granulex found at patient's bedside stand. NH80 11-4-85 Not Corrected NMM 1. Patients were in need of nail care cleaning and trimming of finger-nails. 2. Two patients on seizure precautior were missing tongue blades at the bedside. 3. Uncovered tongue blades found at patient's bedside. 4. A bottle containing blood pressur pills was found at the patient's bedside. 5. A patient was found covered with dried feces. 6. Betadine, Granulex and Hydrogen Peroxide were found at the patien bedside. 7. Foley catheter bags were found wi dark amber urine and large amount of mucus.

NH80 2-13-86 All Corrected NMM

CLASSIFICATION OF DEFICIENCIES FOR
NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
	DIETARY SERVICES 10D-29.110			STATE [illegible] ONLY
NH-116	New substitutions were not consistently recorded for the preceeding six (6) months.	III	8/5/85	NH-116 8/13/85 Corrected. AGJ
	SOCIAL SERVICES 10D-29.115			
NH-198 (F-311/ F-321, F-626)	There was a lack of evidence that needed services were consistently provided to residents and their families to assist them in adjusting to the efforts of illness or long term care. Four (4) of seven (7) medical records reflected psychosocial needs for which there either were no needs identified or no plans stated. Further, quarterly progress notes in two (2) records failed to reflect interventions to meet previously identified needs.	III	8/5/85	NH198 11-4-85 Corrected NMM
	PATIENT ACTIVITIES 10D-29.116			
NH-209 (F-633)	Summaries of activities in medical records were not always timely and did not reflect residents' response to planned programming.	III	8/5/85	NH209 11-4-85 Corrected NMM

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
FIRE PREVENTION, FIRE PROTECTION & LIFE SAFETY 10D-29.119				STATE ACENCY USE ONLY
NH-245 (K-18)	Corridor Walls and Doors The doors to the conference room and the P.T. room need door closers. **Reference:** NFPA-101 (1967) 10-1332	III	8/5/85	NH245 11-4-85 Corrected FWR
NH-250 (K-32)	Exits and Exit Access The folding partition in the dining room blocks exit. **Reference:** NFPA-101 (1967) 10-1212	III	8/5/85	NH250 11-4-85 Corrected FWR
NH-267 (K-29)	Hazardous Areas The ceiling in laundry room had a large hole. **Reference:** NFPA-101 (1967) 10-2351	III	8/5/85	NH267 11-4-85 Corrected FWR
NH-272 (K-61)	Automatic Sprinkler Systems The sprinkler tamper switch did not sound a local alarm. **Reference:** NFPA-101 (1967) 10-1362	III	8/5/85	NH272 11-4-85 Corrected FWR
NH-274 (K-52)	Fire Alarm Systems There was no documentation of fire alarm testing. **Reference:** NFPA-101 (1967) 17-1412	III	8/5/85	NH274 11-4-85 Corrected FWR

Page 5 of 8 Pages

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
	CONSTRUCTION STANDARDS 10D-29.121			STATE AGENCY USE ONLY
NH-296	The soiled and clean laundry functions were not separated.	III	8/5/85	NH296 11-4-85 Corrected FWR
NH-319	There were no lavatory sinks in 4 bed rooms 14-17.	III	9/15/85	NH319 11-4-85 Corrected FWR
	MAINTENANCE 10D-29.122			
NH-352 (P-416/ P-418, P-419)	The interior and exterior of the building was not in good repair, free of hazards, and painted as needed as evidenced by the poor condition of: 1. Interior room and doorway 2. Wall tiles in bathrooms 3. Floor tiles 4. Baseboards 5. Door latches 6. Closet doors and tracks 7. Bathroom partitions paint 8. Handrails 9. Exterior water downspouts (Sections missing) 10. Alleyway ground and walks (green mold covering) 11. Exterior door latch.	III	~~9/3/85~~ ADMINISTRATIVELY EXTENDED To 10/21/85 KK/mm Adm ext. 11/15/85 correspondence on file CEK	NH-352 1/13/86 Corrected BFD

Page 6 of 8 Pages

HHS FORM [illegible], MAR 79 (Obsoletes OPCLC Form R-4)

CLASSIFICATION OF DEFICIENCIES FOR
NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
NH-354 (P-416/ P-418, P-419)	.Plumbing fixtures were not maintained in good repair: 1. Fifty-three (53) Faucets were pitted, corroded and leaking). 2. Fifty (50) water traps were corroded and rusted 3. One-hundred (100) wall collars, water supply tubes and nuts for the tubs were corroded and rusted. 4. Back-up drains in alleyways were clogged. 5. Dryer gasket in laundry was missing and covered by tape.	III	9/5/85	STATE AGENCY USE ONLY NH354 11-4-85 Corrected FWR
NH-355 (P-416/ P-418, (P-419)	Electrical equipment was not maintained in working order as evidenced by: 1. Nurse call cords did not signal from bedside. 2. Light bulbs were burnt out in several areas. 3. Wire on dryers in beauty shop were frayed. 4. Refrigerator was rusted.	III	8/5/85	NH355 11-4-85 Corrected FWR

Page 7 of 8 Pages

HRS FORM [illegible], MAR 79 (Obsoletes OPCLC Form B-4)

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["B"] Nursing Home

Date of Visit July 1-3, 1985

(1) DEFICIENCY AND REFERENCE		(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
NH-357 (P-416/ P-418, P-419)	Furniture and furnishings were not maintained in good repair as evidenced by the poor condition of: 1. Bed frames and casters (rusted). 2. Overbed tables 3. Metal chairs were rusted. 4. Stain on wooden chairs were worn down to the bare wood. 5. Formica cabinets had cracked and peeling formica and needed painting on the inside. 6. The beauty shop chair had cracked arms and peeling fabric.	III	9/5/85	STATE AGENCY USE ONLY NH357 11-4-85 Corrected FWR
	DISASTER PREPAREDNESS 10D-29.126			
NH-400 (P-449/ P-450, P-451)	The disaster plan needs to be reviewed by local fire and civil defense.	III	8/5/85	NH400 11-4-85 Corrected FWR

Page 8 of 8 Pages

HHS FORM [illegible], MAR 79 (Obsolete OFCLC Form R-4)

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

September 27, 1985

Ms.
Administrator
["B"] Nursing Home

Dear Ms.

This letter confirms the findings of a limited scope Medicare/Medicaid, Post Certification and Licensure deficiency follow-up visit conducted on August 13, 1985, by Nancy M. Marcum, R.N. and Anne G. Jackisch, R.D., both of this office. The resident census was 90.

The purpose of this visit was to determine the status of correction of the deficiencies included in the issuance of a Statement of Deficiencies and Plan of Correction (HCFA-2567) for the Federal programs and a Classification of Deficiencies for Nursing home Licensure Requirements (HRS-553D) following the survey of July 1-3, 1985.

Attached is your copy of the annotated HRS Form 553D, which indicates the status of correction for licensure deficiencies at the time of this visit.

It was determined that not all of the deficiencies reviewed had been corrected. A recommendation for the imposition of administrative sanctions pertaining to two uncorrected Class III deficiencies has been forwarded to the Director, Office of Licensure and Certification in Jacksonville. If such sanctions are to be imposed, you will be notified by separate correspondence.

The facility advised that the remaining deficiencies would all be corrected by September 14, 1985. Timely correction of the deficiencies must be accomplished or additional penalties may apply.

You are advised that additional violations of the Rules for Nursing Homes and Related Facilities Licensure, Chapter 10D-29 of the Florida Administrative Code were apparent. These are listed on the attached HRS Form 553A (Statement of Deficiencies and Plan of Correction for Licensure Requirements).

A plan of correction is required for the deficiencies listed along with an associated time table for correction. Please record your plan in the column provided and return the original HRS Form 553A to this office within ten (10) calendar days of receipt. An appropriate signature is also required.

These reports will be submitted for distribution to the appropriate agencies and will be made available to the public as required by Florida Statute 400.191 and Public Law 92-603.

LTC
Sutcliffe

OFFICE OF LICENSURE & CERTIFICATION• 4000 W. BUFFALO AVENUE• TAMPA, FLORIDA 33614• (813) 272-3440
BOB GRAHAM GOVERNOR

If further clarification of this report is needed, please feel free to contact this office.

Sincerely,

Carol E. King

Carol E. King
Senior Human Services
Program Administrator

NMM/jp

Enclosures:	1.	HCFA 2567
	2.	Annotated HRS Form 553D
	3.	HRS Form 553A/Instructions

Copy to:
5DA
5DPOM
5DPOHE
5DLTCOC
LTCOC (Sutcliffe)
LTCOC
DPR
LIB
VA

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

February 24, 1986

Mr.
Administrator
["B"] Nursing Home

Dear Mr.

This letter confirms the findings of a limited scope Medicare/Medicaid, Post-Certification, Licensure deficiency follow-up visit conducted on February 13, 1986, and a surveillance visit in the evening by Nancy M. Marcum, R.N., of this office. The resident census was 97.

The purpose of these visits was to determine the status of correction of the deficiencies which required the inssuance of a Statement of Deficiencies and Plan of Correction (HCFA 2567) for the Federal programs, and a Classification of Deficiencies for Nursing Home Licensure Requirements (HRS Form 553D), following the survey of July 3, 1986, and remaining after the follow-up visit of November 4, 1985, and staffing of the evening shift.

Attached is your copy of the annotated HRS Form 553D which indicates the status of correction for licensure deficiencies at the time of this visit. It was determined that the reviewed deficiency had not been corrected. Timely correction of the deficiency must be accomplished or penalties may be imposed.

A recommendation for the imposition of administrative sanctions pertaining to the uncorrected deficiency has been forwarded to the Director, Office of Licensure and Certification in Jacksonville. If such sanctions are to be imposed, you will be notified by separate correspondence.

Additional violations were noted and are included on the HRS Form 553A enclosed. Please complete your plan of correction and return to this office within ten (10) days of receipt.

These reports will be submitted for distribution to the appropriate agencies and will be made available to the public as required by Florida Statute 400.191 and Public Law 92-603.

OFFICE OF LICENSURE & CERTIFICATION • 4000 W. BUFFALO AVENUE • TAMPA, FLORIDA 33614 • (813) 272-3440
BOB GRAHAM, GOVERNOR

If further clarification of this report is needed, please feel free to contact this Ms. Nancy Marcum at this office.

Sincerely,

Carol E. King
Carol E. King
Senior Human Services
Program Administrator

NMM/pw

Enclosures:
1. HRS Form 553D (Annotated)
2. HRS Form 553A/Instructions

Copy To:
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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE & CERTIFICATION
P. O. Box 210
Jacksonville, Florida 32201

Hospital ______ N. H. __X__ H. F. A. ______ H. S. S. ______	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FOR LICENSURE REQUIREMENTS	Date Survey Completed Follow-up of February 13, 1986

Facility

["B"] Nursing Home

Street Address, City, State, Zip Code

This document contains a listing of the deficiencies cited during the recent survey made by the Office of Licensure & Certification as requiring correction. The Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of licensure requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction.

Summary Statement of Deficiencies Noted With Reference Citation	Provider's Plan of Correction With Time Table
DIETARY SERVICES 10D-29.110 NH-174 The evening meal was served at 6:45 p.m., which was more than six hours from the last meal. Note: Routine meal time is 5:00 p.m. Residents were in the dining room at 4:45 p.m.	
	Provider Representative's Signature ______ Date ______

NMM/pw

Page 1 of __1__ Pages

HRS Form 553A (Replaces form BHF 25-A)

HRS
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

February 24, 1986

Mr.
Administrator
["B"] Nursing Home

Dear Mr. :

The report of the surveillance visit to your facility on February 15, 1986, by Mr. William H. Musgrove and Nancy M. Marcum, R.N., is attached for your information.

The courtesies extended to the representatives of this office are appreciated.

Sincerely,

Carol E. King

Carol E. King
Senior Human Services
Program Administrator

WHM/pw

Enclosure: Visit Report

Copy To:
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5DPOHE
LTCOC
LTCOC (Sutcliffe)
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[illegible] (Sutcliffe)

OFFICE OF LICENSURE & CERTIFICATION • 4000 W. BUFFALO AVENUE • TAMPA FLORIDA 33614 • (813) 272-3440
BOB GRAHAM, GOVERNOR

OFFICE OF LICENSURE AND CERTIFICATION

Visit Report

ADMINISTRATOR: Mr.

FACILITY: ["B"] Nursing Home

ADDRESS:

DATE February 15, 1986 TIME 2:45 p.m.

CENSUS 99 SNF X ICF

Licensure X Medicare X

Medicaid X

LOCAL AGENCY AND PERSON CONTACTED: N/A

METHOD OF CONTACT: VISIT X LETTER TELEPHONE

PARTICIPANTS: Mr. William H. Musgrove, Human Services Program Manager

Ms. Nancy M. Marucm, R.N., Community Health Nurse

Mrs. R.N., D.O.N.

CONSULTATION INSERVICE COMPLAINT INVESTIGATION OTHER Surveillance

CONSULTANT William H. Musgrove TITLE: Human Services Program Manager
Nancy M. Marcum, R.N. Community Health Nurse

SUMMARY: An unannounced surveillance visit was conducted on February 15, 1986, at 2:45 p.m. The purpose of this visit was explained to Ms. Pat Hoppert, R.N., D.O.N., as a surveillance visit based on the findings of the February 13, 1986 follow-up visit.

The facility was toured and the following observations were made:

1. The facility was clean and odor free;
2. Linen was appropriately handled and covered in halls.
3. The majority of the patients were clean and well groomed. There were several patients found with dirty fingernails. Many were out of their rooms about the facility. Persons observed in their rooms, for the most part, were up in chairs. Several of the bed patients were not properly positioned;
4. Morning and afternoon nourishments were passed and the patients were assisted with their feedings;
5. The linen container in the soiled utility room was overfull with dirty linen;
6. Four bed patients were found partially exposed.

Four patient records were reviewed and the following observations were made:

1. Physician orders were documented and followed as ordered;
2. Intake and output records were properly maintained, so that 24-hour fluid balances could be accurately determined;
3. On one chart the patient complained of cold symptoms and there was no documentation found that the nurse notified the doctor or assessed the patient.

PAGE 1 OF 1

In addition, the time sheets were reviewed and staffing appeared to be within the requirements.

An exit conference was held with Ms. , R.N., D.O.N. There appeared to be no violations of State or Federal regulations. The following recommendations were made:

1. Documentation to be completed to include the nurses' assessments of problems and follow-through with patient complaints;
2. Careful consideration should be made with any further admissions of acutely ill patients.

NMM/pw

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

February 28, 1986

Mr.
Administrator
["B"] Nursing Home

Dear Mr. :

This letter confirms the findings of surveillance visits conducted on February 22, 1986, by Nancy Marcum, R.N., and Carol King, and on February 25, 1986, by Ms. Marcum and William Musgrove.

Enclosed is a Statement of Deficiencies and Plan of Correction for Licensure Requirements (HRS Form 553A) which list the deficiencies noted during the visits. These findings were discussed with you and your representatives upon completion of the visits.

Please complete and return to this office within ten days of receipt. Prompt attention and correction of the deficiencies is required. Failure to correct timely may jeopardize licensure.

A recommendation for the imposition of administrative sanctions has been forwarded to the Director, Office of Licensure and Certification. If such sanctions are imposed, you will be notified by separate correspondence.

These reports will be distributed to the appropriate agencies and made available to the public as required by Chapter 400.191, Florida Statutes.

If further clarification is needed, please call this office.

Sincerely,

Carol E. King
Carol E. King
Senior Human Services
Program Administrator

CEK/pd

OFFICE OF LICENSURE & CERTIFICATION• 4000 W. BUFFALO AVENUE• TAMPA, FLORIDA 33614• (813) 272-3440
BOB GRAHAM, GOVERNOR

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE & CERTIFICATION
P. O. Box 210
Jacksonville, Florida 32201

Hospital ______
N. H. x
H. F. A. ______
H. S. S. ______

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FOR LICENSURE REQUIREMENTS

Date Survey Completed:
Surveillance Visit
February 22 & 25, 1986

Facility

["B"] Nursing Home

Street Address, City, State, Zip Code

This document contains a listing of the deficiencies cited during the recent survey made by the Office of Licensure & Certification as requiring correction. The Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of licensure requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction.

Summary Statement of Deficiencies Noted With Reference Citation	Provider's Plan of Correction With Time Table

PHYSICIAN SERVICES 10D-29.107

NH79 - Physician's orders were not followed as prescribed. One patient (whose IV line was removed in error) did not receive a scheduled IV antibiotic that was prescribed by the physician.

NURSING SERVICES 10D-29.107

NH81 - Condition Not Met: See Standards NH100, and NH107.

NURSING SERVICES 10D-29.108

Director of Nursing Services(a)

NH88 - The Director of Nursing did not direct the planning, implementing and evaluating of nursing care services for all residents on a twenty-four-hour hour, seven day a week basis. See NH107.

NH89 - The Director of Nursing did not develop work assignments for all nursing services in keeping with the specific care needs of residents and competency of nursing services personnel. See NH107.

Provider Representative's Signature
Date

Page 1 of 3 Pages

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE AND CERTIFICATION
Post Office Box 210
Jacksonville, Florida 32201

LICENSURE REQUIREMENTS CONTINUATION
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility ["B"] Nursing Home

Street Address, City, State, Zip Code

Summary Statement of Deficiencies Noted with Reference Citation	Provider's Plan of Correction With Time Table
Charge Nurse (b) NH100 - Standard Not Met: See NH102. NH102 - The charge nurse on each tour of duty had not provided supervision to assure that adequate patient care, infection control, patient identification and rehabilitative nursing care were provided as needed. See NH107. Nursing Care (d) NH107 - Standard Not Met: see NH108, NH112. NH108 - Personal hygiene needs of the patients were not met as evidenced by many patients found wet and/or soiled and long dirty fingernails on both visits. NH110 - Urinary drainage bags on several patients had dark concentrated urine. One patient observed had a leaking catheter and the drainage was red colored. NH112 - Many patients were observed, particularly on station 7 who had not received morning care and were still in bed at 11 a.m. on February 22, 1986. Handrolls were lacking for those patients with contractures. NH116 - Inadequate infection control practices were observed. Examples included, but were not limited to the following; a. Oxygen cannulae uncovered and dangling on the floor.	

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE AND CERTIFICATION
Post Office Box 210
Jacksonville, Florida 32201

LICENSURE REQUIREMENTS CONTINUATION
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility ["B"] Nursing Home

Street Address, City, State, Zip Code

Summary Statement of Deficiencies Noted with Reference Citation	Provider's Plan of Correction With Time Table
b. Lack of clean thermometers. The container for the soiled thermometers was found dirty and in need of refilling. Two thermometers were lying on nurses station. C. Trash cans were found without liners. D. A discarded foley catheter and drainage bag was found in the wastepaper basket of a three bed room. E. A patient was found without isolation precautions that had been tested for Aids Profile. NH121 - Patients dignity was compromised. Many patients were observed uncovered and exposed. NH122 - Diets were not served as ordered. Nourishments observed on the nurses' station at 10:00 a.m., had still not been served at 11:30 a.m. One patient who had a diet change on February 19, 1986 was served the wrong diet even after it was brought to the staff's attention. NH128 - Rehabilitative nursing care did not include; a. Adequate positioning; b. Handrolls or other support.	

HRS Form 883 B Aug 77 (Replaces Form BHF 25-B)

Page 3 of 3 Pages

HRS
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

March 21, 1986

Mr. Administrator
["B"] Nursing Home

Dear Mr.

This letter confirms the findings of a Medicare/Medicaid Re-Consideration and Licensure deficiency follow-up visit conducted on March 13, 1986, by Nancy M. Marcum, R.N. representing this office. The resident census was 88 patients.

The purposes of this visit were to determine the status of correction of the deficiencies which required the issuance of Statements of Deficiencies and Plans of Correction (HCFA-2567) for the Federal programs and (HRS Form 553A) for Licensure requirements following the appraisal visits of February 22 and 25, 1986. Concurrently, the status of correction of deficiencies cited during the survey of July 1-3, 1985, and remaining after the follow-up visits of August 13, 1985, November 4, 1985, and February 13, 1986 were also reviewed.

Attached are your copies of the Post-Certification Revisit Reports (HCFA-2567B) listing the Federal program deficiencies that had been corrected, the annotated HRS Form 553D and the Licensure Follow-up Visit Report (HRS Form 553C) which indicates the status of correction for licensure deficiencies at the time of this visit. It was determined that all deficiencies reviewed had been corrected.

Based on these findings, a recommendation to rescind the moratorium on patient admissions was made to our Central Office in Jacksonville on March 15, 1986.

These reports will be submitted for distribution to the appropriate agencies and will be made available to the public as required by Florida Statute 400.191 and Public Law 92-603.

If further clarification of this report is needed, please feel free to contact Ms. Marcum of this office.

Sincerely,

Carol E. King
Carol E. King
Senior Human Services
Program Administrator

NMM/jp

LTCOC
(Sutcliffe)

OFFICE OF LICENSURE & CERTIFICATION• 4000 W BUFFALO AVENUE• TAMPA, FLORIDA 33614• (813) 272-3440
[illegible]

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE AND CERTIFICATION
Post Office Box 210
Jacksonville, Florida 32201

LICENSURE FOLLOW-UP VISIT REPORT

Facility ["B"] Nursing Home Date of Revisit March 13, 1986

Street Address, City, State, Zip Code

This is a report of the status of actions taken to correct the deficiencies reported on HRS 883A, Statement of Deficiencies and Plan of Correction for Licensure Requirements. Enumerated items on this form correspond to the enumerated deficiencies reported on the original Statement of Deficiencies and Plan of Correction. For those deficiencies still not completely corrected, this office will continue to offer its professional consultation in order to assist the facility to meet licensure standards.

Re: Surveillance Visits of February 22 and 25, 1986

ITEM	PRESENT STATUS
NH-79	Corrected NMM
NH-81	Corrected NMM
NH-88	Corrected NMM
NH-89	Corrected NMM
NH-100	Corrected NMM
NH-102	Corrected NMM
NH-107	Corrected NMM
NH-108	Corrected NMM
NH-110	Corrected NMM
NH-112	Corrected NMM
NH-116	Corrected NMM
NH-121	Corrected NMM
NH-122	Corrected NMM
NH-128	Corrected NMM
	NMM/vmh

Signature of Surveyor
Nancy M. Marcum, R.N.

Title Community Health Nurse

Page 1 of 1 Pages

HRS FORM 883C, FEB 1978 (Replaces Form BHF 28C)

HRS STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

May 3, 1985

Mr.
Administrator
["C"] Nursing Center

Dear Mr.

This letter confirms the findings of a Licensure deficiency follow-up visit conducted on April 9, 1985, by Carol A. Edwards, R.N., of this office. The resident census was 108.

The purpose of this visit was to determine the status of correction of the deficiencies included in the issuance of a Classification of Deficiencies for Nursing Home Licensure Requirements (HRS Form 553D) following the survey of January 31, 1985.

Attached is your copy of the annotated HRS Form 553D which indicates the status of correction for licensure deficiencies at the time of this visit. It was determined that all deficiencies had been corrected.

These reports will be submitted for distribution to the appropriate agencies and will be made available to the public as required by Florida Statute 400.191.

If further clarification of this report is needed, please feel free to contact this office.

Sincerely,

Carol E King
Carol E. King
Senior Human Services
Program Administrator

CAE/pd

Enclosure:
1. Annotated HRS Form 553D

Copy to: 5DA
5DPOM
5DPOHE
LTCOC
LTCOC (Sutcliffe)
5DLTCOC
DPR
LIB

5DLTCOC

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE & CERTIFICATION
P. O. Box 210
Jacksonville, Florida 32231

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS

NURSING CENTERS, INC. d/b/a

Facility ["C"] Nursing Center Date of Visit January 31, 1985

Street Address, City, State, Zip Code

Column (1) Contains a listing of deficiencies observed during the survey conducted on January 31, 1985 and regulatory references.
Column (2) classifies the deficiency in accordance with Chapter 400.23 of the Florida Statutes.
Column (3) lists the date by which the deficiency must be corrected.
The licensure law provides for penalties as follows: $1,000 to $5,000 for Class I; $500 to $1,000 for Class II; and $100 to $500 for Class III.
Column (4) is reserved for state agency use and will be used to document the status of corrections on the dates of revisits.

(1) DEFICIENCY AND REFERENCE	(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
MEDICAL RECORDS 10D-29.118			STATE AGENCY USE ONLY
NH-231 Nursing services failed to accurately document physicians' telephone orders. They did not contain basic information such as frequency of treatment or nourishment.	III	3/4/85	NH-231 4/9/85 CORRECTED CAE
CONSTRUCTION STANDARDS 10D-29.121			
NH-341 Receptacles within five (5) feet of a sink in the beauty shop were not provided with ground fault interrupters.	III	3/4/85	NH-341 4/9/85 CORRECTED CAE
STATUTORY REQUIREMENTS			
NH-408 The facility failed to post either a copy of the last survey report or a summary thereof.	III	3/4/85	NH-408 4/9/85 CORRECTED CAE
JLK/pw			

FEB 20 1985

Provider Representative's Signature

Date 2-20 85

Page 1 of 1 Pages

HRS
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
MEDICAID PROGRAM OFFICE
2255 East Bay Drive, Clearwater, Florida 33546

Date: July 25, 1985

Administrator
["C" Nursing Center]

Dear Mr.

The attached Facility Evaluation Summary represents the findings of the INSPECTION OF CARE completed on July 11, 1985.

The Summary contains the observations, conclusions, and recommendations of the Medicaid team concerning the adequacy, appropriateness and quality of all services provided in the facility or through other arrangements, and compliance with Federal requirements relating to medical records.

Your facility was found to be in compliance with the Federal and State rules, regulations and policies governing Inspections of Care in skilled nursing facilities and intermediate care facilities with the exception of the following:

☒ Medications & Treatments
☒ Tests & Observations
☒ Plan of Care
☒ Professional Progress Notes
☒ Health Care Services Including Mental Health
☐ Social/Activity Services
☐ Certification/Recertification
☐ No Corrective Action Necessary

It is requested that you submit and implement a corrective action plan on the above checked items within 15 days of the exit interview.

Your assistance and cooperation are appreciated. If you have any questions, please contact this office at 813/536-5911.

Sincerely,

Mary Ellen Grose
(Mrs.) Mary Ellen Grose
Senior Human Services Program Manager
Medicaid Program

cc: Office of Medicaid Program Development (2)
~~Utilization Review Committee~~
Long Term Care Ombudsman Council - District V ✓
, President; Nursing Centers

MEG/mlg

DISTRICT FIVE
BOB GRAHAM, GOVERNOR

FACILITY EVALUATION SUMMARY - ["C"] NURSING CENTER - VISITED 7/11/85

MEDICATIONS AND TREATMENTS

(1)b. - 12 records contained unsigned and/or undated orders.

- Telephone orders were not transcribed to the current computer order sheet.

- Several orders for discontinuation were carried on the computer sheet up to 6 months past the discontinue date - i.e.: a physical therapy order - an order for a physical therapy evaluation was carried for 6 months after order discontinued. Orders were incomplete on the computer sheet regarding vinegar and water with no purpose stated. There were omissions in transcribing orders from one month to the next as in the case of eye drops, laboratory orders and ointment for decubitus treatment.

- There were conflicting activity orders such as up ad lib versus up in chair 1 hour.

(2) - There were omissions in administration or charting on 8 records such as: no site documented for intramuscular injections on 4 records, no documentation of Apresoline with no reason for omissions, Restoril daily at hour of sleep given only 4 times with no reason documented, Betadine ointment ordered but not used and no reason given, Centrum not administered with no reason documented.

- There were errors in administration on 6 records such as: medications ordered daily were initialed for 2X a day, after meal medications were scheduled for before meal, Digoxin ordered on 4/20 not administered until 4/22, an order for Dulcolax 2 tabs. discontinued by error, p.r.n. medications were not utilized as needed as patients were documented as having impactions removed frequently and on one resident 4 weeks in a row with no laxative utilized; one record indicated no bowel movement for the entire month, which may have been either an error in administration or an error in documentation.

(3) - 18 records were incomplete: 1 record lacked an ordered pace maker check, 7 records lacked ordered laboratory reports or chest x-ray, intake and output records were incomplete, recorded monthly weights were missing on several records, vital signs such as weekly blood pressure and daily apical pulse were incompletely documented, supplements were incompletely documented.

FACILITY EVALUATION SUMMARY - ["C"] NURSING CENTER - VISITED 7/11/85

PHYSICIAN/NURSING SERVICES/OTHER PROFESSIONAL SERVICES

(1) - 5 records contained telephone orders undated and/or unsigned. Duplicate slips were still on several records with signed and dated telephone orders.

- 1 record had no doctor's progress notes documented for over 60 days.
- Care plans were incomplete on 27 records:
  - Problem of resident pulling out foley 7 times in 6 weeks.
  - Problem of resident with foley catheter plugging frequently necessitating replacements.
  - No address of leg braces, presence of foley catheters, skin care problems due to incontinence, thick toenails on a diabetic resident with need for podiatry care, residents with hearing problems, eye problems, weight losses, abusive, aggressive behavior problems, history of seizures.
- Care plans needed updating to current status of residents.

(3) - Meal intake is not routinely recorded on a daily basis at this facility.

- 3 records were incomplete regarding food allergies not addressed on dietary histories.
- 3 records had no dietary progress notes for over 90 day periods. Overall dietary progress notes and histories were complete and informative.

(4) - Physicians' progress notes were legible, up-to-date and accurately descriptive.

- Nursing monthly summaries were complete and well organized.
- Nursing progress notes were incomplete and/or inconsistent on 17 records.
- Many records contained 1 line references to eye conditions, skin conditions, falls, bruises, and other injuries, with no further address.
- 1 resident had weak spells documented for 3 weeks with no documentation of doctor being notified but there was documentation that resident did not want to be ambulated and used these weak spells for sympathy. Resident was admitted to hospital after doctor visited and noted "pasty" color. Hemoglobin was 5.2 just previous to hospital admission.
- Records were inconsistent regarding continence, weight loss or gain, drainage and appearance of skin lesions, eyes and rashes.

(5)a. - Cleanliness of environment was acceptable. Cleanliness of residents was the prime concern. On interviewing residents who were bedfast at the time, many were wet and incontinent of bowel, nails were long and feces stained on almost all complete care residents.

- Clothing was food-stained after meals and not changed when observed several hours later.
- A used urinal was left hanging for several hours on the clean linen cart which was uncovered and easily accessible to anyone passing in the hallway.

(5)a. Cont'd. -

- Residents were placed in wheelchairs and gerichairs around the perimeter of the nurses' station and were observed in various stages of undress, disarray and were obviously not taken to restroom facilities as needed.
- 1 resident was placed in the dayroom in a wheelchair, but with her feet bare. She was unable to propel herself away from another resident in a moving wheelchair and was in danger of having her toes run over or caught in the wheels.
- Another resident was observed with thick, purulent, eye drainage.

b. - 13 residents were being treated for ongoing eye drainage, decubiti, skin tears, excoriations and rash.

- TED hose were not being used as ordered, in one instance, the reason was that they were being laundered.
- Residents with dependent edema and with orders to elevate legs were sitting for hours in wheelchairs and with legs down.

c. - 10 residents had appreciable weight loss over a 2 or 3 month period.

- Hydration appeared to be poor as evidenced by dark, foul urinary drainage with much mucous and sediment and documented frequent catheter plugging and leaking.

d. - From a nursing viewpoint, the maximum physical and mental functions were not maintained at maximum for these residents.

- 22 of 67 records reflected evidence of behavioral and/or adjustment problems such as: negative attitude, crying, verbal and physical abuse toward staff, agitation, restlessness. It is recommended that in-service training be provided for staff to assist with the direct care of residents exhibiting negative behavior.

HRS
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

January 21, 1986

, Administrator
["D"] Convalescent Center

Dear Ms.

This letter confirms the findings of a Medicare/Medicaid Post-Certification and Licensure deficiency follow-up visit conducted on December 13, 1985, by Jim E. Holcombe and Dorothy I.Brown, R.N., representing this office. The resident census was 97 patients.

The purpose of this visit was to determine the status of correction of deficiencies which required the issuance of a Statement of Deficiencies and Plan of Correction (HCFA-2567) for the Federal programs and Classification of Deficiencies for Nursing Home Licensure Requirements (HRS Form 553D) following the survey of October 22-24, 1985.

Attached are your copies of the Post-Certification Revisit Report (HCFA-2567B) listing the Federal program deficiencies that had been corrected, and the annotated HRS Form 553D which indicates the status of corrective action for licensure deficiencies at the time of this visit. It was determined that all deficiencies had been corrected.

These reports will be submitted for distribution to the appropriate agencies and will be made available to the public as required by Florida Statute 400.191 and Public Law 92-603.

If further clarification of this report is needed, please feel free to contact Jim Holcombe at this office.

Sincerely,

Carol E. King

Carol E. King
Senior Human Services
Program Administrator

JEH/vmh

SDLTCOC

OFFICE OF LICENSURE & CERTIFICATION • 4000 W. BUFFALO AVENUE • TAMPA, FLORIDA 33614 • (813) 272-3440
BOB GRAHAM, GOVERNOR

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
OFFICE OF LICENSURE & CERTIFICATION
P. O. Box 210
Jacksonville, Florida 32231

RECEIVED
DEC 02 1985
OPLCT, TAMPA

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS

Facility: Convalescent Center, Inc. d/b/a ["D"] Convalescent Center

Date of Visit: October 22-24, 1985

Street Address, City, State, Zip Code

Column (1) Contains a listing of deficiencies observed during the survey conducted on October 22-24, 1985 and regulatory references.
Column (2) classifies the deficiency in accordance with Chapter 400.23 of the Florida Statutes.
Column (3) lists the date by which the deficiency must be corrected.
The licensure law provides for penalties as follows: $1,000 to $5,000 for Class I; $500 to $1,000 for Class II, and $100 to $500 for Class III.
Column (4) is reserved for state agency use and will be used to document the status of corrections on the dates of revisits.

(1) DEFICIENCY AND REFERENCE	(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
NURSING SERVICES 10D-29.108			STATE AGENCY USE ONLY
NH-75(F-131) The charge nurse on each tour of duty did not fullfill their responsibility to see that the total nursing care needs were met. (See NH-80)	III	Immediate	NH-75 12/13/85 Corrected DIB
NH-77(F-135) The Director of Nursing Services did not ensure that the facility's patient care policies and procedures and the policies and procedures developed by the Infection Control Committee were properly implemented. (See NH-80)	III	Immediate	NH-77 12/13/85 Corrected DIB
NH-80 Twenty-four hour nursing care provided did not meet the needs of the patients as evidenced by the following:	III	Immediate	NH-80 12/13/85 Corrected DIB

JEH/jp

1. STATE AGENCY

Title: Administrator

Date: 11-25-'85

Page 1 of 4 Pages

HRS Form 5530, Oct 79 (Replaces previous edition)

CLASSIFICATION OF DEFICIENCIES FOR NURSING HOME LICENSURE REQUIREMENTS CONTINUED

Facility ["D" Convalescent Center]

Date of Visit October 22-23, 1985

(1) DEFICIENCY AND REFERENCE	(2) CLASS OF DEFICIENCY	(3) MUST BE CORRECTED BY	(4) DATE OF REVISIT AND STATUS OF CORRECTION ON DATE OF REVISIT
1. Inadequate personal hygiene and patient comfort. 2. In-house developed decubiti. 3. patients wet with a foul urine odor and dried urine rings on sheets. 4. Patients sitting in chairs with their bare feet on the floor. 5. Lower extremities dry and flaky. 6. Unshaven male patients. 7. Poor infection control practices. (See NH-365)			
DIETARY SERVICES 10D-29.110			
NH-125(F-246) The following violations of Chapter 10D-13 F.A.C. (Food Service Code) were observed:	III		
1. Shelving in the walk-in refrigerator was rusted and needed refinishing;		11/28/85	NH-125 12/13/85 Corrected JEH
2. Raw meat was being drfrosted over other food which would not be subjected to cooking; and		Immediate	
3. The person operating the dish machine did not wash/sanitize his hands in-between handling dirty and clean dishes.		Immediate	

Page 2 of 4 Pages

HRS FORM 5535, MAR 78 (Obsoletes OPCLC Form R-4)

HRS
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
MEDICAID PROGRAM OFFICE
2255 East Bay Drive, Clearwater, Florida 33546

Date: February 6, 1986

, Administrator
["D"] Convalescent Center

Dear :

The attached Quality of Care Summary represents the findings of the QUALITY OF CARE REVIEW completed on January 28, 1986.

The Summary contains the observations, conclusions, and recommendations of the Medicaid team concerning the adequacy, appropriateness and quality of all services provided in the facility or through other arrangements, and compliance with Federal requirements relating to medical records.

Your facility was found to be in compliance with the Federal and State rules, regulations and policies governing Quality of Care Reviews in skilled nursing facilities and intermediate care facilities with the exception of the following:

☒ Medications & Treatments
☒ Tests & Observations
☒ Plan of Care
☒ Professional Progress Notes
☐ Health Care Services
☐ Social/Activity Services
☐ Certification/Recertification
☐ No Corrective Action Necessary

It is requested that you submit and implement a corrective action plan on the above checked items within 15 days of the exit interview.

Your assistance and cooperation are appreciated. If you have any questions, please contact this office at 813/536-5911.

Sincerely,

Mary Ellen Grose

(Mrs.) Mary Ellen Grose
Senior Human Services Program Manager
Medicaid Program

cc: Office of Medicaid Program Development (2)
Long Term Care Ombudsman Council - District V ✓

MEG/mlg
6QCLTR

["D" Convalescent Center]

COMMENTS & RECOMMENDATIONS:

- Inservice training should be scheduled to emphasize facility policies regarding infection control, documentation responsibilities, adequate management of professional responsibilities of care provision.

- Monitoring systems should be increased to provide improved charting systems and quality of information recorded.

- Supervision of licensed nursing personnel must achieve a reliable quality of professional management of care provision, maintain a continuity of ongoing documentation of condition status and provide timely communication with physicians regarding condition changes/problems in care management.

- The corrective action plan requested following the last Quality of Care Review pertained to medication and treatment and testrand observations - the plan indicated the nursing supervisor would monitor daily and weekly. This procedure should be reviewed and revised to prevent further omissions/errors as noted at this time since ongoing problems exist.

- Management of dietary progress notes and content of information has improved, is well written, addressing the individual needs of each resident.

- Management of care plan reviews with family participation in meetings is well documented and timely. Continuing efforts to update and include all facets of care needs in the plans should be emphasized.

- Housekeeping and maintenance employees are to be commended for providing a clean, odor-free home for these residents.

- Copies of all nursing assessment forms documented for this review are being retained in the facility for teaching and/or corrective action.

- Recent staff changes and implementation of new procedures are reflected in current documentation and care provision with improvement noticable.

- The receptive attitude and assistance provided to the MQC Review Team is greatly appreciated.

M D 2/6/86
Physician Date

Irene J. Preble 1/31/86
Nurse Date

Lynn Stevenson 1/31/86
Counselor Date

Others Date

QUALITY OF CARE REVIEW SUMMARY - ["D"] CONVALESCENT CENTER - VISITED 1/28/86

ATTACHMENT A

II. A. Physician Orders -

1. Dolobid ordered - not provided X7 days.
2. Order for catheter omitted from monthly orders but implemented for several months.
3. Eye consult ordered and achieved but no report from physician provided or requested.
4. Telephone order signed by doctor and unit nurse but void of order.

B. Medications & Treatments -

- Unit nurses failed to maintain professional duties as reflected by documentation - i.e.:
  - 7 of 52 records reviewed reflect errors/omissions in medication distribution - i.e.:
    1. 11/22 Americar QID X5 days ordered - given 1 dose every day 11/23 11/24 then QID X6 days.
    2. Artane marked D.C. on Medication Administration Record (MAR) - no order to D.C. recorded.
    3. Keflex ordered X7 days - given X9 days.
    4. Geocillin QID X7 days - given as ordered but 5 capsules returned to pharmacy.
    5. Afrin nasal spray BID omitted 9 pm dose 3 of 5 days ordered.
    6. Medications not given - on leave of absence - no documentation why not given after return or sent with resident on leave of absence.
    7. Vitamin B12 1M Q mo. omitted December dose.
  - At least 4 records indicated p.r.n. ordered laxatives not given during recorded extensive periods (6 to 9 days) of constipation. At least 3 of whom have had resultant documented fecal impactions.
  - At least 8 records reflect use of p.r.n. ordered medications for which documentation is incomplete by omitting the time effectiveness of medication is assessed.
  - At least 47 records reflected use of Kwell treatment for which documentation is incomplete regarding application, removal procedures and condition of skin prior/following application.
  - Abdominal binder ordered (1) - never documented as implemented (verbal information reveals resident will not tolerate).
  - Catheter irrigations at 2:00 pm omitted X22 in November.

QUALITY OF CARE REVIEW SUMMARY - ["D"] CONVA[illegible]R - VISITED 1/28/86

ATTACHMENT B

II. C. Resident Care Plans (RCP) -

At least 10 records reflect care plans that are incomplete - i.e.:

1. RCP goals for weight loss inconsistent with food supplements ordered T.I.D. for weight gain.
2. Update needed regarding assist/supervision with ambulation because multiple falls have occurred.
3. Need for special shoes secondary to deformed toes.
4. Update needed regarding prevention consitipation.
5. Update needed regarding rash.

E. Diagnostic Tests -

- Diagnostic laboratory studies not done in timely manner - primarily, electrolytes ordered every 3 and/or 6 months were not done in appropriate time frames. Continuity with orders must be maintained as directed.

III. - Documentation fails to adequately reflect facility policies are maintained regarding infection control, hydration provision, monitoring of vital signs during acute illness periods - i.e.:

- documentation of infection control measures to prevent spread of "flu" type illness occurring in epidemic numbers in facility during December and January is not documented for residents with documented symptoms. 12 residents with symptoms were hospitalized with concurring diagnoses of U.T.I., U.R.I., pneumonia, bronchitis, dehydration, congestive heart failure, septicemia.

- Documentation of intake/output is not provided for residnets with need for increased fluids due to fever elevations and/or urinary tract infections associated with catheter care.

- 13 residents of the 14 with foley catheter care reflect urinary tract infections have occurred during the review period. House policy indicates change is indicated if irrigation fails or accidental removal occurs - some of the catheters were last documented as changed 4 months prior to this date. (10/6, 10/14). Orders for catheters do not include the size to be used and documentation does not provide sizes of catheters inserted in most instances. Those with documentation provided reflect wrong size used for 1 resident with size order 18 with 5 cc bulb a 22 with 30 cc bulb used; one undetermined size removed - 26 with 30 cc bulb used for replacement.

- Unit nurses failed to provide documentation containing monitoring of vital signs following identificationof acute illness patterns and provision of ongoing information regarding symptoms occurring - i.e.: temperature elevated to 102°, no information for 2 days when temp. of 103° recorded; diarrhea occurring with no follow-up information/vital signs; nausea, vomiting occurring with no vital signs recorded.

- Among those affected with increased illness patterns during this recent period delays occurred in contacting doctors about increase or new symptoms - i.e.:

  - "nausea/vomiting" "increased congestion" - 12 days duration before call to doctor.

["D" Convalescent Center]

ATTACHMENT B Cont'd.

- Temperture elevated/diarrhea - 2 days duration before call to doctor.
- Frequent use of N.T.G. for chest pain through November - doctor not notified.
- 12/26/58 - "pallor, weakness, B.P. 90/60 possible over sedation" documented, probably from use of new order for Navane 5 mg QID given for 9 days - doctor notified 10 1.m. 1/6/86.
- Eleven residents have falls recorded - i.e.:

  1 - falls 11/27,11/28 to hospital 12/29 for pneumonia documentation regarding condition between falls incomplete

  1 - falls 11/30,12/30 "found in bathroom after toileting" doctor had written "patient too weak to be alone out of bed".

  1 - fall 12/1 "found on floor" no vital signs recorded - no follow-up.

  1 - fall "found on floor" "no injuries" - skin tear on hand treated following day.

[COMMITTEE STAFF NOTE: The following documents were submitted for the record by Kansans for Improvement of Nursing Homes, a nursing home residents' advocacy group. The documents consist of transcribed conversations of friends or family of nursing home residents, pertaining to their observations in 47 Kansas nursing homes during the period 1984 - 1986.

Also appearing in this appendix is a published excerpt of a record from a state administrative hearing pertaining to violations of health and safety standards by a Kansas nursing home. The excerpt focuses on testimony, provided by a State nurse inspector, to document the violations cited by the State.]

KINH News

KANSANS FOR IMPROVEMENT OF NURSING HOMES, INC.
913 Tennessee, No. 2 • Lawrence, Kansas 66044 • (913) 842-3088

SPECIAL SERIES
VOL. 1 NO. 1

About "Inside Kansas Nursing Homes"

This first part of the Special Series of the KINH Newsletter marks the begining of our report on the quality of nursing home care in Kansas as seen through the eyes of relatives and friends of nursing home patients. Frequent visitors to nursing homes are best able to observe actual day to day care; their comments are therefore deserving of our closest attention.

We began our conversations with them in June, 1984. All comments presented in this Special Series have been taped and transcribed since that date. We talked with some individuals privately; we also held group meetings in several Kansas communities. We have edited the comments to omit mention of non-recent events or of any references which might pinpoint speakers or patients. All names of speakers, patients, and staff members have been changed.

Nursing homes discussed are identified by a number, arbitrarily assigned, and by geographical region: NW, NC, NE, SE, SC, and SW. For example: #3 NW. Nursing homes mentioned only in passing are assigned alphabetical letters. For example: Nursing Home A.

These conversations with relatives and friends of patients will be continued until we have received comments on at least forty to fifty percent of the total number of homes in the state (370).

Volume One, of which this issue is Number One, covers about 38 nursing homes. It will be published in serial form over the next few weeks.

Petey Cerf, Editor

INSIDE KANSAS NURSING HOMES

RE: Nursing Home #1 NW

Number of nursing homes in this town: two

Those attending this meeting did not know who is responsible for nursing home regulation.

AUGUSTA: When they tell you, "Well, if you don't like it, you can lump it. You can take your people someplace else," that makes you think really that they really don't care.[8] I have a sister, Helen, in #1. Helen went in 1980. She is on welfare. Helen had had a series of strokes and had paralysis on the one side, and wasn't able to help herself. Well, when she couldn't walk by herself, she needed a wheelchair. They told her she wasn't entitled to a wheelchair because they didn't have enough to go around, and the welfare patients didn't get them. The aides shouldn't have to know whether these people are on welfare. They should get the same treatment whether they are on welfare or not. We bought her a wheelchair then. But whenever Helen has to wait for the bathroom (she's diabetic and has to go quite often), and I've been in there, they've waited anywhere from twenty minutes to an hour for someone to come and take her to the bathroom.[1]

The aides have dropped her before and then denied it.[6] She was sitting in the wheelchair and apparently the aide just couldn't—some of them I don't think have been taught how to handle people[5]— and Helen just slipped out of her hands and she went down. And the aide told us, "Helen isn't hurt." She said, "I've checked her over and she's not hurt." But she did have a skinned place on her arm and she was skinned on her toe. This aide said to us, "Now, don't you go down to the office and tell on me and get my ass in trouble." And that's just the way she put it. And I told the administrator about this, and she said she'd check on it.

I complained when Helen was having all this trouble with her insulin, being diabetic. Four mornings in a row that she passed out with insulin shock![3] I went up one morning when they'd put Helen back to bed (it was about eight o'clock), and Helen was just completely out. They didn't seem concerned. They just took her and put her in bed and went off and left her. They just weren't checking on her.[7] Well, I went up there and talked to the administrator and told her why I was up there and what is was all about, and she passes the buck, is what she does. She called down to the nurse and told her I was there and that I was coming down to talk to her, and I went down there to talk to the nurse, and she said, well, there wasn't much they could do about it, that Helen was all right, that she just needed to feed herself. And I said, "Now, I've come from Helen's room, and she's completely out. I couldn't even get her to talk to me." (Because the nurse had said, "I've talked to Helen and she's all right.") This was ten-thirty or a quarter to eleven. And they'd taken her back there about eight o'clock, and nobody had been back to check on her!

About insulin shock, I know for a fact that that day on the charts that the nurse had written down on Helen's chart, "Appears to be drowsy and sleepy." And nothing about insulin shock on that chart. And so I went the next day and talked to her doctor and told him about it, and he said, "You know, they have never called me about it." When I confronted the nurse about it, I said, "Have you called the doctor about this?" She said, "They're welfare patients. They're only entitled to one doctor call a month. They can only have one doctor's call a month."[8] And so I went down to the doctor's office, went over and sat in his office (took my time, I wasn't sick, but I sat so that I could see him), and

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I told him about her passing out, and he said, "They never called me about her insulin." He was to go the next day, and he did, and he reduced the insulin, and she's doing much better. I told him what they had said that she could only have one call because she was welfare, and he said, "That's not right." And so he did check, and they reduced the insulin, and she's so much more alert again. And even her toes and those places are healing better since they've cut the insulin.

The trouble was, they gave her the shot too soon. They gave it at six and she doesn't eat until probably about seven-thirty. She's supposed to have it only twenty to thirty minutes ahead of time—of breakfast. And then, of course, when she's been having these little "mini-strokes" as the doctor calls them, sometimes she can't feed herself, because she gets a little paralysis. I've seen her when she couldn't get her hand up to her nose.

And she can't feed herself and they don't help. They're supposed to help the ones that can't feed themselves.[6]

When Helen first got up there they were always telling us that she was always falling. Now, whether they were dropping her or what I don't know. I think what they'd do is they would put her in the bathroom and then they wouldn't come back to get her off, and she would try to walk back to bed by herself. And she fell many times.[3]

About a year ago, when they didn't have air conditioning (the air conditioner didn't work in her room), and so we were up there, my husband and I, and we took the cover of and it was completely clogged with lint and dirt on there that you couldn't get any air through it. And so we asked them about it. Well, they gave us all kinds of excuses. Each room, you know, has their own heating and cooling. And they finally did give her a new unit, and it did work then for the rest of the summer. And then in the winter at Christmas, she had a miserable Christmas, her room was so cold. She sat huddled in blankets because it was so cold.[3] And I asked whether I could take a heater in for her. And they said, "No, they're too dangerous." The excuse that they gave is that her room is at the end of the hall and the heat didn't get that far. But they each have got their individual units! The unit was faulty and they wouldn't fix it.

We had a man that was a friend of ours that died up there, and he had holes clear through his hip bones. Where his hands lay, he had sores on his hands. Even his hands where he lay.[6]

I think their biggest problem is lack of staff. I think they're grossly understaffed.[1] Many a time in the night, like from eight o'clock until eleven, one of them goes home and leaves one on the floor; one aide on the floor for the whole sixty patients, or whatever they have.[3] There's one of the aides who comes at three, I think it is, and she only works until like eight o'clock. By then they don't have most of them in bed, and so that leaves one aide on the floor to get all those people and ... So when I jumped the administrator about this, she denied it. She said, "I'm overstaffed now." She honestly told me this, "I'm overstaffed now." Eight to eleven is really a critical time, getting those people to bed. And they had a patient up there last week that fell and broke her hip.[3]

I know here at the home they have run out of food before. They have run out of milk, and they have run out of juice. They run out of bread. And they'll be without these things for a week.[3] And there's grocery stores right there. They say that they have to wait until their supplier comes. But there's grocery stores right here in town. Do you know what they feed them up here? Sauerkraut and wieners, tacos, lasagna, all of this hot and spicy food, Chinese food (which my sister just hates), Chow Mein. Oh, I've seen there are meals so many times that look like slop. I don't think a pig could eat some of that food they put out for them. They post a weekly menu out here, but what they've got on the board up there and what they get are two different things.[6] You see, they put it up there for the public to see, and it doesn't look that bad when you read it. And fresh fruits! They never get fresh fruits, prunes. I do take them. And now some of these church groups that come by do bring them bananas and oranges a lot of times.

They've all had constant coughs and colds this winter, and every time they've had any medicine prescribed, they've had to wait anywhere from a day and a half to two days to get it. It's *there*. The drugstore sent it out. It's there. But the patients don't get it.

Do you know what they do when they don't want to hear the buzzers and the lights? They turn them all off so that they don't buzz.[6] The administrator told me that all Helen had to do is buzz. And I said, "Hers does not buzz." She said, "Oh, they all do." And I said, "No, they don't. Hers never has buzzed up there. Besides that, they turn them off at the nurses' station so that they don't all ring at once.

AMY: My mother was in #1 for two years. I was up there every day for a couple of hours. I gave her baths and fed her and cleaned the room when I thought it needed it, which was almost all the time.[9] My primary complaint is that they were understaffed.[1] I didn't really have any complaints with the individual people, but they didn't have enough of them.

When the ombudsman came out, it jacked them up a little bit, and they put some more people on. And then it faded away again. We found out what they did. They have to have a ratio—you know, so many staff members per patient—but we found out they were counting everyone, cleaning ladies, everyone.[6] I can count. I mean, I know how many patients there were. They are posted on the wall. And I knew how many they had "on", because I was there for every shift. Every week I was there at least once in every shift. I know for a fact that there were evenings (from three to eleven) when they didn't have enough people to get them all to bed.[3] They put mother to bed as early as six-thirty in the evening, because they couldn't possibly get around to everybody. Like, two or three girls putting sixty people to bed. And that is simply not enough.[1]

BETTY: There's been three of them here recently on. I've been countin' 'em of a morning when they leave.

AMY: Well, they have so many people to feed at one time that it is impossible to feed everyone while the food is warm. Somebody has to eat cold food. And that's not very nutritional. That is why I went up a lot and fed mother, because it just absolutely wasn't getting done, and she couldn't help herself at all.[9] I wanted her to eat something warm.

I did a lot of things, scrubbed the floor, because it wasn't getting done and I didn't want her to suffer for it.[9] You can't

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just say, "Well we're paying," if they don't do it. I complained to the administrator, and she told me, "You are aware we can force you to remove your patient."[8] I said, "Try it." As long as I am paying, they can't.

I found that the owners always knew when the state was coming.[10] You could tell when you walked in, because everything was fresh and clean, and they were ready. So I got ahold of the ombudsman and I told her, "If you can't come unannounced, don't bother." She came out unannounced and laid her credentials on the desk and said, "I'm from the Kansas Department on Aging, and I'm here to check on staffing, because of complaints."[1]

The administrator's jaw just dropped. And it got better after that for awhile. They had more people on for a little while, and then it sort of faded away again, you know. Well, you might tell everybody here that it was our Representative who gave me all the telephone numbers. He was a big help. He called me from Topeka and gave me all the numbers I could call and complain to. And that's finally where I got the Department of Aging and the Ombudsman. I called him once, and then he called me back, like three times, to see if I had had any success. He was a big help. In my opinion, staff should be counted as only the people who are doing the personal care, answering the lights; the nurses are so busy with paperwork that you can't really count them as answering the lights, you know. And I know how much time it takes to care for patients. I've worked at the hospital a number of years, and I know what it's like to work short-handed. There's only sixty minutes in an hour, and if you are already two of you in a room lifting a patient, nobody's answering the lights.[1] And the next person's light may be just as important as the one where you are already at! But you can't be there.

VOICE: They have so many over there, too, that are bedfast and that need continuous help, for baths, and so on.

AMY: And it takes two of them sometimes, or three, to do it, at one time, you know. There are basically just three types of people that work in nursing homes. Either they are totally dedicated no matter what the conditions, or they can't get anything else and they are just there until they can,[2] and the rest simply can't get another job because they're not competent. That's the three groups of people that work there.

BETTY: Like those two that they have working there that the owners have looked after all these years, Carolyn and Dorothy. They neither one are competent. They really *are* retarded. Well, that Carolyn was in a home herself for a long time. She's the one that poured hot water on ninety-seven year old patient when she was bathing her.[6]

Nothing was done about it. Who's going to take the word of somebody that's old, a patient who is blind and deaf and ninety-seven years old. She was red enough that her relative asked her what was the problem. And she-well, you know, they don't want to say anything. They don't want to say anything for the simple reason that they will have something taken out on *them*.[4] So finally, the patient said Carolyn poured hot water on her when she was bathing her. I think she works now over there at the other home in town (Nursing Home A).

People don't understand until they actually have somebody that is in a nursing home. Most people don't want to be bothered with such things. I've had my mother in #1 five years. She is completely immobile. She had a stroke. She is sixty-five. And she is confined to a wheelchair all the time. She has to be lifted to the bathroom and to and from bed. Anything that she does she has to be lifted. Of course, she has no muscles left. With her one leg she can push herself a little bit. And mentally, her mind isn't that good any more. Her care lacks a lot of be desired. She feeds herself. But, like she told me here a couple of years ago, she eats like a pig. They feed her back in her room now. They used to bring her out to the dining room. She does holler a lot, so I suppose that's why. I get in a fight with them every time I go over there and I get real upset. But my husband told me, "If you're not satisfied with the care move her someplace else." But I just don't feel like I can. I'm the only one. . .the only family she has. And that's the closest home to where I live.

It seems to me like we just put them in there to *die*! Now, this is really, truly, what I feel about it. And not a thing in the world I can do about it. It's real heartbreaking to see somebody that you love and some of your family in that position and know she is crying.

AMY: They have such poor equipment that it takes the staff much longer to do their job. For instance, they have no fitted bedsheets. OK. You pull a patient up and all the sheets go with them. And then they've got wrinkles, and then they get bed sores.[3] And then the beds, the handles fall off when you try to roll the head up. If they had electric beds there *are* bed patients that could lower their heads and raise them and feed themselves. They wouldn't have to turn that light on. They have the cheapest possible equipment.

BETTY: You know, so many of them when you ask them. . .I know my mother when I ask her, "How are you today?" she'll say, "Fine." "Are you getting good meals?" "Yes."

AMY: But they don't have enough linen.[6] They used to run out of towels. I brought towels from home.

BETTY: Well, I know that the laundry person up here at #1 is limited. She has guidelines. She can only use so much detergent a month and so much bleach, and so she has to do with what she has got.

AMY: Why can't the regulations be enforced more strictly, like, in a hospital, you either pass it or you lose your accreditation.[5] That's it. Or they could give them enough time to clean up their act. And if they don't they could fine them. It's like with other laws, whether it's traffic laws or whatever. They are absolutely useless unless they are enforced. We have gotten patients in at the hospital from the nursing homes, and the doctor says, "Clean the patient up. I will not examine him under these circumstances." We have had some bed sore patients in. I can think of one in particular that was so bad the doctor took her to surgery to fix it. Down to the hipbone.[3]

BETTY: Well, when I had my mother there at Nursing Home A, I went in and many times I have turned her bed back and her sheets and everything would be sopping wet, and they had just made her bed *up*. I would open her drawer. There would be her wet gowns and things in her drawer with the

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rest of her clothes. I have pulled them all out and threw them on the bed. We had a patient over there at #1 the other day, she is new over there. I was there and talked to her. She is not a diabetic. They put her in there because she just had a few more weeks to live. She told me that they gave her an insulin shot last Sunday a week ago, and she had *never* had an insulin shot.[7] They turned right around and realized what they had done. So they called her doctor and he came and spent the evening with her at the nursing home to see that she didn't have an insulin reaction.[3] It was at the patient's insistence that they called the doctor. Otherwise they would not have called.

AMY: Well, I think if anyone wants to learn what is going on, they should chose an inopportune time to visit it, as far as the home is concerned. Eight-thirty just before they close the doors. About breakfast time. Mealtime. When they least expect visitors, and then you can kind of see what's going on.

I stayed a couple of nights with Mother. I was up there like at ten-thirty, eleven o'clock sometimes. They have to let you in. If you are a family member they have to let you in.

GERTRUDE: I am one probably with the least experience in nursing homes, but we entered my father at Nursing Home B two weeks ago today, and the only reason that we didn't go here to #1 is because of the horror stories that we have heard for years. Everyday I drive to see him. He's getting off to a good start over there. I have never yet been there when there's been soiled linen or anything of the kind around. Dad was somewhat self-sufficient at home until the time he fell (which precipitated this—by the way). He's ninety-four and had been living alone until he fell, but these people over there are truly caring people. The turnover there has been very minimal. I feel that this is one of the better homes in our vicinity, and I have not met one single aide or nurse or LPN that did not have a caring concern for every person there. I went every day for the first week. I was there three times last week. My brothers and sisters were in accord with me in putting him over there. There was an opening here, but I would not consider it, for the very reason of the stories or the *truth* that I have heard of the care that they receive here. At Nursing Home B, they change the bedspreads every other day. Their linens are changed every day. They take the dirty linens at the end of the day when they are dressed for bed, take it to the laundry and it is laundered and cleand and in the closets the next morning.

HANNAH: Ken's father entered #1 in October of eighty-two, and he could not stand it. His meals were cold; he couldn't eat them. Well, you have heard all the stories. And he did get better, and with nursing care we were able to take him out. But, then he became ill again in March a year ago, and we tried to get him into Nursing Home C. We thought we were going to have to take him to #1 again, because they always have room for patients, it seems like. But the morning that we were going to have to move him they called us from Nursing Home C. There was a vacancy and they could take him there. Well, they were very, very, angry with us at #1.[6] We really got told off, but we moved him to Nursing Home C. He is very happy there. He does not complain. They have wonderful food. They cleaning lady is always cleaning. The rooms are spic and span. You open the dresser drawers and everything is clean. The hairdresser goes there once in awhile and she said, "Oh, this place is so nice to come to. Everything is so clean." and she said, "I've been up to #1 and you wouldn't believe how that was dirty and wood rotting under the sink."[6] But the only thing they do complain about is that they ring the bell and they don't come quick enough, at Nursing Home C. Now whether that is because they are old and they want to be waited on immediately or whether that is true—that they don't have enough help. They are full most of the time with a waiting list. We never go down there but what they are bringing laundry to the rooms. And everything's clean and also we never go down there but what the cleaning lady is mopping the floor. They just shine; everything's clean.

AMY: I think the people who own #1 are simply not interested in taking care of people. They are interested in lining their pockets. It's just that simple. It's not the budget. They just want the cost down, spread their profit a little, you know. I mean their profit margin. The best defense up there at #1 is a complaining relative or somebody who cares. I know I admitted my aunt Friday. She has nobody else here. When I got up there and did the paperwork, they said, "Are you the responsible party?" And I said, "Yes." They weren't real thrilled with me. They know I'm going to be in the office every other day!

Once they understood with my mother that she was not *mentally* incompetent, that she was just physically incapacitated. . .They used to try to tell me, when she said it took so long to answer the light,[1] they would say, "Well, she doesn't remember. She's not aware of the passage of time." It was not so. She was. And so is my aunt. It has nothing to do with her mind. It is strictly physical, and she knows *exactly* when they are coming and when they are not. And when you can prove that to them they shape up just a little, but that probably makes life for somebody else miserable.

They had volunteers sort of up here. They call them, "Senior Companions", and they used to have at least four of them, and then when they cut the funds they're down to two now.

BETTY: Yes, but they don't do anything really.

AMY: Well, when mother was in there, that one gal that's been in there for so long she did a marvelous job. Mother was always thrilled when she fed her, becuase she was very patient and everything.

BETTY: I've seen them take them outside. This is fine. The ones that can take care of themselves can get up and walk and take care of their physical needs and everything. That's fine. But that is the ones that they are always doing for. It's not for the ones that really *need*, you know, need the help. I've gone back there and my mother hasn't even had a cup of water or not even a *cup* back there or a glass of water.[9] They don't even put 'em a glass. I've made them take her back glasses. I've made them take washcloths and things back there.

AMY: Well, I just went in the linen closet and just dumped out the towels I wanted.[9]

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BETTY: Well, I do too. I do too. But then that's not my place.

AMY: No, but I *did* it.

BETTY: Another complaint that I have is this. I have all the compassion in the world for the mentally retarded, so don't misunderstand what I'm saying. But the mentally retarded had the full run of the facility. What they would do is go into some of these rooms, and it would make some of these patients so nervous that they could hardly stand it. And I really felt that if they were going to keep them there that they should keep them in another wing. And you go in and you walk down the halls, and they are saying, "Hi, Betty," and they're hanging onto my arm, and they are walking all the way until someone says, "Get away."

AMY: And of course, they're lonely.

BETTY: *Sure* they are. Sure they are.

AMY: I don't understand this: when our hospital got so slow up here, with patients, there were aides there that had worked there for seventeen or eighteen years. And, you know, they have all kinds of training in every department. And they went over to the rest home to apply, and they said they weren't certified. They couldn't work there.

RE: Nursing Home #2 NW

Number of nursing homes in town: two

Mr. Parsons did not know who is responsible for nursing home regulation in Kansas.

MR. PARSONS: My mother entered #2 in 1984. She is very nearly blind and her diverticulosis is pretty bad. She is ninety-one. Her mind is not what it used to be, but for ninety-one years, it's not too bad. I hope I can do as well.

I think they're, I'll say "weak", as far as the care, because we're pretty much agreed on that. I am over there almost every day. Does get the cat off of her back. As hard a time as she has had adjusting and some of the actions of the force over there, I feel so far that I'm obligated. She is now adjusting a little more, and hopefully it's for the best.

Now the aides, that's the pet peeve. There's a big change, turnover.[2] Some of them are taken in without any training. And some of them that have been there long enough to know, don't set the world afire. At the very best, there are not enought aides.[1] And when some of them don't show up, it's still worse. That's what happens. I imagine they are paid minimum wage. But that can't. . .well, to me the administration should see to it that patients get care regardless.

I see the administrator when I go to the office. He doesn't go around much. Not near enough. I haven't complained except to the chief nurse. I took it up with her because my mother was refused to use the phone.[6] I don't know why. I haven't figured that one out. She didn't give me any reason. No, what she did is she denied it. She got mad. That made me mad. Then she went in her office and did some calling, to call a couple of aides that had been on duty. And she came back out. She was in an altogether different mood. She said, "I'm sorry. I'm just awful sorry."

I'd say the food is fair. I think probably that in the wing my mother's in, it's not served as quick as soon as it's taken out of the kitchen. It's, well, warm. I think the other two sections, it would be better.

I have two other acquaintances that are in the east wing over there, which is where they say they keep the most serious. And they don't have a call bell where they can reach it, purposely. The help won't be bothered answering the call bell. I think it would be easier to be bothered, but they don't.[7] But this friend, she's had a stroke and her left side is completely paralyzed and she cannot help herself, and when I found her in bed, they didn't have the call bell where she could reach it.[6]

If mother's doctor happens to be at the nursing home he has stopped in a time or two, but mostly I have taken her down to the doctor's office. Medication, well, that's one of those things that the chief nurse and I didn't get along on. I had talked to the doctor about the medication and he was ready to change it. And then one of the aides had told my mother, no sleeping pill after two o'clock.[8] Well, I had taken that up with the doctor, and he had agreed with me. And I told the chief nurse I wanted to see the chart. And she gave in, not gracefully.[8] I'm smart enough to know that with the power of attorney and closest relative, that they'd better show me the chart. And it was scripted PRN.

The nurse let me know that if my mother gets a sleeping pill too late, she'll be drowsy before noon, and I said, "The doctor and I have already discussed that, and if she does, I'll be the first one to let you know." She just wanted me to know she was boss.[8]

I want to say one thing: it had been four years since I'd had anybody in there, and the service there has deteriorated no end. If the administrator was out there on the floor seeing what was going on, I can't help but feel that it would be different. The administrator don't see through those walls very good.[7]

RE: Nursing Homes #3 NW and #4 NW

Number of nursing homes in town: two

Those attending this meeting did not know who was responsible for nursing home regulation in Kansas.

MAGGIE: Things are quite a bit better at #3 than a few months ago. They are keeping my daughter cleaner. The main thing that I have at this time is, when they take her out to the dining room for her meals and so forth,—she can't walk by herself because she falls— and they just leave her sit in there; just sit in there time after time. I've had some of the help out there tell me, sometimes they leave her sit in there after the meal almost to the point till the next meal, and she can't go to the bathroom or anything.[6] She gets so weary, she almost falls out of the chair, she's so tired. She hasn't fallen out yet by the grace of God. It's just a plain old chair like you sit at the table.

I've talked to the head nurse and I've talked to different ones out there. I just remind them she should not be sitting there that long. They just say, "Oh, well, we'll remind somebody to take better care of her." But it stays the

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There's not enough help.[1] That's the main trouble, I think. The meals are, I would say, skimpy.

NORA: My grandmother's been in#4 for two years. About the food, for instance, Saturday night, they didn't have hardly anything to eat. On the weekends is the poorest time, and on Sunday is when we always had our big meal. You know, it used to be families had their big meal on Sundays. And those women are the ones that *did* have. And now, if they are there on Sunday, it's usually very poor. We get the teenagers to cook, or I can't say who cooks, but they don't know how to cook. In fact, none of them hardly know how to cook. But why can't they cook the food good? I have met with the dietician, and she says, "I can put the recipe up there, but I can't tell them how to cook." They get the trays mixed up, and people get different diets than they are supposed to have.[8] Because there was some special food for two at granny's table, and one of the ladies didn't get it. They should have their name, but they put the name on the wrong tray, that's all. Granny will have sometimes as many as three kinds of fruit on there and no vegetables. Now, it's easy to open a can and put a pear on the tray or put two peach slices, and if we don't have all those places filled we can put some applesauce there or something, you know. And never a balanced diet! There's no balanced diet.[8] They have the poorest of meat, too, up there.

RUTH: No, it's not the poorest meat, it's the way it is cooked.

NORA: Well, I know, but they don't go down and buy prime meat. and when you are paying thirty-nine dollars and twenty cents a day you really deserve some good meat. On Saturdays they don't have decent food, practically nothing! They pay the same on that day as they do on Monday and Tuesday. They have chili or they'll have bean soup, you know. They give them chili soup. Hot and spicy chili.

ALMA: Dad says if they bring potato soup out, it's just as thick as can be. Just all gluey. They cook their food forever. I heard one of the girls say that lunch was ready to serve at eight o'clock in the morning. Now, if you cook it for four more hours, you know why it tastes like it does.

RUTH: And about half the time it is cold as ice.

ALMA: it's cold when it gets out there. They have a microwave already, but I told Dad, they're only in more trouble, because you can make that patty of meat burn crisp in the microwave.

PEGGY: Mildred Murphy fell. She lay there from about two in the morning until about eight in the morning.[6]

ALMA: Dad heard her call and call and ring that bell, and nobody there.

PEGGY: They discovered she had broken her leg, and she was in *bad* shape there for awhile.[3] She was going to the restroom. She wasn't supposed to be up walking by herself, but if she would call to go to the bathroom it was a long time,[1] and so she would get up and go by herself, and when she came back she got disoriented, I think, and tripped over the foot of the bed. I told her next time to use the bedpan.

NORA: Those girls should really go up and down those halls at *least* every thirty minutes. Ought to be *one* go up there and down every night.[7]

ALMA: I don't think they walk that hall.

NORA: They never do. I don't think.

RUTH: They're supposed to do a check, but I don't know if they do.

ALMA: If they do one check a night, it's good. For water, they don't even see that they get a prayer of water. My Dad's will sit on his dresser, and his juice will sit there.[3]

RUTH: They don't give it to him.

ALMA: No, and he can't get it. There's a table next to his bed, but he can't reach it. He is a twenty-four hour patient. He can't even dress himself anymore, or like that.

The aides come in and he is setting there. Why don't they take the glass and say, "Won't you like a drink?", because he's not going to ask for it. They should say, "Here's a drink."[7] "Here it is." He doesn't talk. With me, I pull it out of him.

Last night I said, "Dad, did you miss me?" "Yes, I did." Well, maybe that's all he said all week. He doesn't talk. He doesn't ask. When he is ill, he doesn't tell me; he doesn't know. Here, last week I went in and at noon he was just really great. He was happy; he acknowledged me and all. I went back that evening, and I thought he had been slapped off his chair with a wet mop, the way he looked. He just looked like he was ready to drop off his chair. I could tell something was the matter with him. "Daddy, what's the matter?" He looked at me. I said, "Daddy, do you hurt someplace?" He just looked. And I said, "Do you hurt here?" He had a bad sore throat. When I finally got a sound out of him, he was as hoarse as could be, see. His throat was sore, see, but he wouldn't say anything. And the girl says, "Well, he didn't *say* anything." Well, of course, he don't!

RUTH: I would tell them that my mom was sick, and they would say, "Well, we asked her if she felt OK, and she'd tell us, "Yes."

ALMA: She doesn't realize the difference, then. My dad is the same way.

RUTH: The aides are supposed to check people every two hours when they are incontinent. And I've been there when I know that they haven't changed her. It's been more than two hours.[6]

They had to have a paper towel dispenser. they finally got them in there. And they had to have soap dispensers, too. They were getting deficiencies on those. And mother's room never has regular towels and washcloths in it.[5] When they go to clean her up, somebody's got to go get the towel and washcloth. And there's hangers there for it.

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The Kansas Department of Health and Environment is responsible for nursing home regulation.

ALMA: I figured if I had been back there in Dad's room, if there was a washcloth there that would be for him, I could wipe his face and hands, but there was never anything.[5]

NORA: There are in Granny's!

PEGGY: That's what I say. If they are alert enought to holler, they can ask for it. But if they're not. . .and that is not right!

ALMA: They can ask for it. But just let them *not be* alert that way, and you will see the kind of care they get![6] And nobody can see it!

RUTH: In my mom's room, they'll say, "I've got to go and get some towels and washcloths." But those should *be* there. They use them, they need to go get some clean ones and put them back.

NORA: Now the toilet tissue. The girl came down the other day and Granny had part of a roll, and she said, "I can't leave this; it has to be empty before I can leave another one." This was one of the girls. She couldn't leave an extra one that Granny could put on herself. But, you might wait three days for her to come back. You could be out the next time you went to the bathroom. I said, "Be sure to ring your bell when that gets almost empty."

PEGGY: When a person has nobody, no family, nobody that really has the authority to say anything, it's *very* disturbing. Like poor Georgie.

NORA: Oh, he's so withdrawn. It's terrible. And he used to have some clay that he worked on all the time.

PEGGY: He just stands in the hall now, because he has no access to anything he can do.

NORA: You know what he used to have? Clay. He had a table at the foot of his bed that he had his clay on.

PEGGY: But Yvette didn't want this kind of stuff around there, so she took it all away from him. She was the administrator last year.

Why don't aides have to go someplace and really *get* their training before they handle aged people?

ALMA: Why, I've seen them coming in one day and they just show them around. And you go back the next day and there she was feeding them and going down to get a patient. Didn't have no pin on. She wasn't certified.[5]

RUTH: There were so many people in there. You'd go in and you didn't know what that aide's name was, and maybe she'd be there a week and then she was gone.[2]

ALMA: Sometimes she was there one day, too.

RUTH: There was a time when everyone was new. You didn't even know their names.[2]

The following Resident Rights are excerpted from *Regulations for the Licensure and Operation of an Adult Care Home*, Kansas Department of Health and Environment, Barbara Sabol, Secretary; Forbes Base, Topeka, Ks 66620; 913-862-9360.

Resident Rights (KAR 28-39-78)

Resident rights; rights standard. (a) The licensee shall assure the residents their rights as persons and citizens which include:

(1) **Rates and Charges.** The resident shall be fully informed in writing, before or at the time of admission, of the services available in the facility. The licensee shall inform the resident of any changes in daily or monthly charges or services which occur after admission, at least 30 days in advance of the effective date of the change;

(2) **Medical Information and Treatment.** The resident shall be informed by a physician of his or her medical condition, unless it is medically contraindicated as documented by the physician in the medical record. The resident shall be given the opportunity to participate in the planning of medical treatment. The resident has the right to refuse examination or treatment. The resident shall give informed, written consent to participate in experimental research;

*(3) **Transfer and Discharge.** The resident shall be transferred or discharged from the facility involuntarily only for medical reasons or for the welfare of the residents or others, or for nonpayment of the rates and charges imposed by the adult care home. Except in emergencies, the resident or legal guardian shall be given written notice at least 15 days in advance of a transfer or discharge of the resident;

*(4) **Exercising Rights.** The resident shall be provided the opportunity to exercise rights as a resident and a citizen. The resident shall have the right to voice grievances and recommend changes in policies and services to facility staff or outside representatives of the resident's choice, without restraint, interference, coercion, discrimination, or reprisal;

(5) **Financial Affairs.** The resident may manage his or her personal affairs;

(6) **Freedom from Abuse.** The resident shall be free from mental or physical abuse;

Continued on page 8

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(7) Freedom from Restraints. The resident shall be free from restraints unless the restraints are authorized by a physician for a specific and limited period of time or when necessary to protect the resident from injury to self or others;

(8) Confidentiality. The resident shall be assured confidential treatment of personal and medical records and may approve or refuse their release to any individual outside the facility, except in the case of transfer to another health care institution or as required by law;

***(9) Privacy.** The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. Residents shall have access to an area for reading, meditation, solitude, or privacy with visitors or other residents;

(10) Work. The resident shall not be required to perform services for the facility that are not included for therapeutic purposes in the plan of care;

(11) Correspondence. The resident shall be permitted to associate and communicate privately with persons of his or her choice and send and receive personal mail unopened, unless medically contraindicated as documented by the resident's physician in the medical record. All outgoing resident's mail shall be mailed promptly;

(12) Freedom of Participation. The resident shall be permitted to participate in social, religious, and community group activities at his or her discretion, unless medically contraindicated as documented by the resident's physician in the medical record;

(13) Possessions. The resident shall be permitted to retain and use personal clothing and possessions unless doing so would infringe upon the rights of other residents or unless medically contraindicated as documented by the resident's physician in the medical record;

(14) Marital Privacy. If married, the resident shall be assured privacy for visits by the spouse. If both are residents of the facility, they shall be permitted to share the same room unless medically contraindicated as documented by the resident's physician in the medical record; and

(15) Choice of Pharmacy. The resident shall have the right to choose the pharmacy where prescribed medications are purchased. When the facility uses a unit dose or similar medication distribution system, the resident shall have the right to choose among pharmacies that offer or are willing to offer the same or similar system as that used in the facility.

(b) Policies and Procedures. The licensee shall establish and implement written policies and procedures regarding the rights of residents. They shall:

(1) Prohibit abuse, neglect, or exploitation of residents;

(2) Assure that the resident or the legal guardian of the resident is fully informed of the rights and all rules and regulations governing resident conduct prior to signing the written admission agreement;

(3) Provide for written, signed acknowledgment of this information from the resident or the legal guardian of the resident before or at time of admission; and

(4) Assure that all staff of the facility is trained and involved in the implementation of the policies and procedures.

*These rights are of particular importance.

KINH News

Kansans for Improvement of Nursing Homes, Inc.
913 Tennessee, #2
Lawrence, Kansas 66044
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913 Tennessee, No. 2 • Lawrence, Kansas 66044 • (913) 842-3088

SPECIAL SERIES
Vol. 1, No. 2 September 1985

INSIDE KANSAS NURSING HOMES

RE: Nursing Homes #5 NW and #6 NW

Number of nursing homes in this town: two

ALICE: My sister, Etta, has been in #5 three years. She is completely bedfast. She does not feed herself. She can't eat alone. She has a permanent Foley. She has to have enemas because she can't eliminate on her own. She can't turn. She has to be handled like an infant. She has been that way now about two years probably. They say she's had *little* strokes. The last hospital said that they had diagnosed Alzheimers. First we heard the 'chronic brain syndrome', and then we heard the 'senile dementia', and now the first thing we heard them come up with is the "Alzheimers."

She doesn't talk, she babbles. We don't know if she recognized me or not. She will follow you with her eyes, and make some motion to you or something—like raising her head up off the pillow. But she can't ask for anything. Everything that's done for her, anything, any care, it has to be done. If she doesn't ask for a drink of water, she won't get it. And if she has pain, she can't tell you. The only way I can tell is by looking at her eyes, I can tell if she is not feeling well—you know, if there's something really radically wrong. And then some of her actions—I can kind of tell that way. With the mind, it's hard to tell. And *they* can't really tell you anything either. Sometimes they will say, "She's not experiencing any pain." But I felt that she was because of some of the reactions that she had—the reactions that she *does* have. She *does* feel pain.

And the care! God forbid. I hope I don't ever wind up there! I mean, if I've got a mouth that I can speak for myself, and if you've got a brain to still comprehend what's going on and can still *say* what's bothering you—then I'd say your chances are pretty good. Because you can still bitch! You know, you can still do it on your own. But if you can't you are at someone else's mercy. Now, if I'm not there, then she's *at* someone else's mercy. And I don't think that I am being overly expectant, that I expect that *much*. Especially if I'll go back and ask them and check the BM book, or something. (They're always pretty good about that. They'll open the book and let you see, you know.) And if you will go back in the book four or five days without a BM—and she's a heavy eater! I mean, what you call a good eater; she eats her three meals, and she eats everything that's put into her mouth. She'll eat it.

So after four or five days, they'll give her an enema. She had a routine set up when she's supposed to have enemas twice a week—every Monday and every Thursday. She would evidently get those enemas, and then I would ask, "Well, what results?" Well, there was no results, or small results, or something.[7] And then I'd raise all kinds of Cain. Well, then they'd go ahead and do something, and *then* they'd get results.

She had an impaction this last time. They had to put the tube down the stomach and pump the stomach.[3] And then—we almost lost her through impaction and kidney infection. Never enough liquids![3] She has, like I said, a permanent Foley. If she doesn't get enough liquids the infection builds up, you know an awful lot of sediment. There's times when the stuff came through the tube that looked like cream. I mean, you just can't explain it unless you've seen it yourself. And, God forbid, I've seen it since she's had that Foley, for three years now. The doctor said to change the Foley every three weeks or once a month, or to irrigate it. Now, they stopped the irrigation on it because

About "Inside Kansas Nursing Homes"

This is the second Special Series KINH Newsletter which contains our report on the quality of nursing home care in Kansas as seen through the eyes of relatives and friends of nursing home patients. Frequent visitors to nursing homes are best able to observe actual day to day care; their comments are therefore deserving of our close attention.

We began our conversations with them in June, 1984. All comments presented in this Special Series have been taped and transcribed since that date. We talked with some individuals privately; we also held group meetings in several Kansas communities. We have edited the comments to omit mention of non-recent events or of any references which might pinpoint speakers or patients. All names of speakers, patients, and staff members have been changed.

Nursing homes discussed are identified by a number, arbitrarily assigned, and by geographical region: NW, NC, NE, SE, SC, and SW. For example: #3 NW. Nursing homes mentioned only in passing are assigned alphabetical letters. For example: Nursing Home A.

These conversations with relatives and friends of patients will be continued until we have received comments on at least forty to fifty percent of the total number of homes in the state (370).

Volume 1, of which this issue is Number 2, covers about 38 nursing homes. It will be published in serial form over the next few weeks.

Petey Cerf, Editor

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every time you open a Foley you leave yourself open for infection to begin with. And with her getting her enemas and stuff like that, the excretion will back up into the urethra track anyway, so she's going to wind up with an infection regardless. It's just an automatic thing. But they *have* to give her enough liquids in order to flush that darn tube through.

And sometimes it was so blocked that nothing was going to come through! I mean, it was just really *bad.*[7] And so I bitch about that again. And I know the one night when we took her to the hospital the last time, there was—when I came out there, there was *thick* stuff in the tube, and blood was in there, and I know that we've got problems when we reach that point. And then we took her to the hospital. I think I must have been there until about nine or nine-thirty when we got everything finished and got the doctor and all that, and got her admitted. I think we must have got her in right close to midnight. And *that* is when they had to pump her stomach—the impaction clear up—the foul smell, I mean, you know it was just—

It's hard to talk about it. It's hard to say, especially when it's your own—and it's been a fighting battle. I mean, you'll ask—to be nice, you'll *ask* for awhile.[7] Then after awhile you'll get so frustrated you start *demanding.*[8] I mean, you really get to bitching. And I'm a bitcher, and they know it when I walk in over there. It's all I've got left of the family there, you know, and if we don't look out for them, my God, who will?

One man I talked to, he wanted to go to the bathroom the other night—and this is an every night routine—he comes to me because I go out there every night. (I've been feeding my sister now, since she's down, I've been feeding her every night and giving her bed baths and her peri care.) And this old man wanted to go to the bathroom. And he'll say, "Alice, I gotta go again," and I'll say, "Well, can't you find somebody out there at the desk?" "They don't give a damn," he said, "They don't *give* a damn."[8] And I said, "Well, let me go find somebody," and he said, "It's always the same thing over and over, 'I don't have the time. I don't have the time right now.[1] I'm busy right now. I'll be back.' " And he said, "So I *wet*, you know, in my—" I said, "Well then, wet! Then make them change it." He said, "Oh, God, I *hate* that." It's degrading to have his *mind*, you know, but he can't walk to the bathroom.

And so they put the dry pot on him—the disposable panty thing, you know. Well, it's like a diaper. They put that on him, and just last night he was sitting there and squirming around in that chair—just *squirming* and lifting one leg up. And I said, "What's the matter?" and he said, "They've got that damn thing on so tight it's hitching one of my testicles."[7] The man was uncomfortable. Now, this is *twice* where they had this thing on so tight that the man was just miserable, and I said, "I can't change it; I can't go in and loosen it up," so I grabbed one of the nurses or one of the aides and I said, "Get in there and loosen that up on him. It's pinching him so bad he can't hardly stand it." So she did, but I was standing there you know. I was *standing* there.

The people that have no one. No family. Oh, God. I have wondered many a time. There's one lady that's been there as long as my sister has, and I have not seen a soul come to visit her at all. I don't know the lady. But you just wonder—

They're not given enough *motion* to keep from stiffening up.[7] It's so *damned easy* to put them in a wheelchair because it *goes faster!*[8]

They're short-handed, understaffed.[1] I don't know what the ratio is. I don't know what the regulations are as far as state requirements--so much help, you know, per ratio to so many patients—I don't know. I think the whole damned bureaucratic system is all screwed up. They can take their paperwork and wipe themselves with it. They've got so many inches for this; so many feet for that. You've got to have so many feet distance from this and for that. Who cares! It's the *care* of the people that matters.

I've been there when the State's been there. And they just got through over there again, just this last week, I think it was. And, like I said, I've been feeding my sister there for over two years, and I'll go into the kitchen. I'll get her tray. I'll get her liquids, and I've been giving her a lot of prune juice—thank the Lord for prune juice. God knew what he was doing when he made prunes, because that's a good laxative, and I've been giving her that, and she's been doing a lot on her own now, so thank the Lord we found something. But anyway, I went into the icebox like I've been doing. They're so damned short-handed,[1] so I went in and I got the juice and poured it and got the tray ready like I always do.[9] Well, they were there. And the next night or a couple of nights later I went in and I headed back to the icebox again, and one of the girls said, "Hey, Alice, that's a no-no." And I said, "Oh, since when?" And they said, "Just this morning." And I said, "I was not aware of it, and you didn't see me get the juice. This will be the last time." And as I poured it out I asked what happened. She said, "Well, evidently they must have seen somebody come in and go to the icebox unauthorized." And I said, "Who in the hell is more authorized than me? I've been coming in here long enough that I guess they ought to know me." And I said, "If they saw anybody it was likely me." So now they've got a black line down on the floor. Nobody goes beyond that. It's like kids in school, you know—"Don't step over the line!" Then they've got another black strip which kind of eliminates the working area.

So I said, "OK, now what in the hell am I going to do about her juice. You guys back there, who are short-handed to begin with and have got a helluva time putting the food out in the plates, how are you going to take time out to get me her juice yet?" "Oh, we'll get it." And now the juice is ready when I get there. But how long is this going to last? I have seen this time and time again. I have seen it, and there are a few more that have been going there long enough, and they have seen that when they bitch long enough, they'll get the results for the time being, and then that's it.

I've called my local Health and Environment office, and she wanted me to call someone in Topeka, and I said, "Well, let me keep an eye on how this is going and I'll get back to you." This was just a few weeks ago.

Now, this other lady was out there, her mother had been in the hospital for severe dehydration.[3] Her mother's another one that can't ask for a drink and can't get her own.[5] And I think that was the third time that she had been in the hospital for that. She was there about a week, this last time.

1st VOICE: Will they never learn? They can walk in and out of there and never offer anybody a drink.

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2nd VOICE: Never, ever, offer my mother a drink.

3rd VOICE: Those aides can walk in there to maybe put them on the bedpan, but do they ever offer a drink?

BETTY: My mother's in #5 too, but she's been in the hospital sometimes ten days at a time, a week at a time, and she gets IV's going every minute, she's so dehydrated. She was out there one time with pneumonia. She was out there with pneumonia, and both times they had the IV going every minute she was out there. And that happened other times, too. She has been in the hospital a lot *because* she was dehydrated.[3]

ALICE: Betty's another one that feeds her mother. Betty is an old aide, too, like myself. We've worked in hospitals, and if we'd have given care like that we'd have got fired.

BETTY: In seconds!

ALICE: Yeah, in a second.

CAROLYN: But the care is really worse on Saturday and Sunday.[6] The care is worse on weekends. There's less help. "We just can't get to you, because—"[1]

ALICE: Well, right now they're working double time, double shifts.[1] Which aide was it came in—Phyllis came in at five-thirty in the morning the day before yesterday. She is one of the aides. She's supposed to work the seven-to-three shift, or whatever it is. Well, anyway she worked her shift, and then she had to stay over until eleven o'clock that night. She couldn't hardly even walk anymore, she said, her feet were hurting so bad. And then there was another one of them that had to come in like that and work over, too. There were two of them.

I think they do pay overtime. I don't know how they can get around it. I know I've heard them comment that they're going to have to get some help, because they're really griping about all this overtime. And this had been going on now for awhile, where they've been so short-handed that those girls have been pulling double shifts. I mean *double* shifts.[1]

They're short-handed because *nobody stays*. It's not in the budget. That's always the thing the administrator says, "It's not in the budget." It's her pet phrase.

And then, too, they get them that can't get work somewhere else. Just very poor help. Can't get other jobs.

DAVID: Well, one thing—you're talking about the turnover—since Sheila's been there about eighteen months—she has a lot of brain damage, but she knows anybody that comes in there—but there have been over a hundred and eight different people that served her at night in this eighteen months.[2] I keep track of them.

The nights are the worst. The only time I can go up there is at night. The daytime couldn't be as bad as night. There's no help there.[1] Sheila is at the end of the hall and they run out of juice before they get there, and I say, "Listen, I'm paying forty-one dollars a day, and go get the juice."

One gal came in and brought the juice in and laid it over there by the lavatory. Here's Sheila in bed and she can't move![6] Then another one comes in and says, "We've only got prune juice tonight." Well, hell, she doesn't want prune juice. She doesn't want milk. Anyway, it's something like that almost every night. But anyway, I appreciate what they *do* do.

One time the nurse came down and said, "I understand that you have complained?" And I said, "Sheila hasn't had a towel or a washcloth for a week."[6] She looked over there and there wasn't a damned thing there. She couldn't believe it.[7]

And everytime they change the beds, or change the sheets, they never hook the thing up where the light is, so she could pull it if she needed it.[5] Maybe they'll do that right one time out of a hundred. You don't *believe* that they don't do that; you'd think they would do that.

ALICE: Well, now you see, David, she can still use the light. They don't put the cord on her bed for her to reach it! Here's my sister who doesn't even know that a cord is a cord, and they've got the damned thing hooked on her bed.

VOICE: They don't want to hear the bell.[6]

DAVID: They never hook it on. And Sheila could use it. And the bedding. I had given her some candy or something to eat, and she kind of, you know, gets stuff all over herself. She still feeds herself. I tried to get them to feed her, but they don't want to feed her because they think that's just another thing that makes her do less than they want.[7]

ALICE: But she really needs someone to feed her, David. I see her at the table—[6]

DAVID: Oh, yeah, I took her clothes home and washed them always until the last two weeks.[9]

ALICE: She's not getting enough vitamins—

DAVID: No, I take her something every night. A banana or something. I take her something every night, a candy bar. I've never missed a night. In eighteen months I've missed six nights. At first I would go up two or three times a day, and then two times, and then break it off. But if I had to rate them—I can't compare them to other places, because this is the only place I know—but if they were rated on a one to five I would have to give them a two. It seems like the help, they're interested in feeding *themselves*—oh, yes, they just love to feed themselves and get together, yeah.[7]

ALICE: And, boy, don't get in their way when it's time to eat.[8]

DAVID: And then another thing, they're always in that little cubbyhole, and they talk too much. And there will be a couple of lights on, and they'll all be sitting there talking.[7] And it seems like they're always *filling out* something. I don't know what the hell they fill out, but they're always working on that. They spend more time working on that than anything else. And evidently they just love to do that. The Head Nurses—the girls at night, they're nice old girls—they don't have any guts at all. They just let everybody run them.[7] I can't believe it.

One of the residents there said that at night she can't sleep very well. So she goes into the dining room and she'll have her cigarettes and stuff, and she said every night she'll come in there and you can look over there on the

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couches, and there's three of them laying on the couches there sleeping. That's on the eleven to seven shift. They're over there sleeping![5]

ALICE: Probably three aides on at night, along with the Med. Aide.

DAVID: The other night, one lady was there. She had her two kids with her. She had to bring her kids up there because she got a call at the last minute to work.

ALICE: She was a Med. Aide.

DAVID: We've had this happen two other times. "Did you see my little kids? They called me at the last minute and I had to come up." Now, weekends—like you mentioned, Saturdays and Sundays— are *unreal*.

One Saturday night two different people called in at the last minute. So there was *one* person going up and down trying to do everything at once, and it was something else![3] No way they could take care of them.[1]

The head people meet with me. Oh, I've met with them three times. I at least do all my complaining to them. And they listen. And people who are there, I'm sure they want to do what is right, but they are short on time. Let someone else talk—

ALICE: The organization of the whole thing is unorganized.[7] Let me get in there, God, I'd of wrung some necks! I'd of straightened it out. I'm not bragging. I'm just stating a fact.

DAVID: I'd like to see it.

ALICE: Anybody that has any sense at all—

DAVID: Absolutely. Or any authority.

ALICE: Damn it, you're not going to get it done any other way. In fact, when Elsie was there (Elsie used to be Head Nurse), I said, "Elsie, do you know that those girls waste more time down at Hall Three (which is the heavy care) going down looking for somebody to help lift this one, get her out of bed and put her in a wheelchair? They waste more time. Put them *together*," I said, "Start them on one end and get them *in* there. One of them can strip the bed; the other can get them up, comb their hair, then that one can wheel them out. Then they can go on to the next room. Work in *teams*." And she said, "Well, aren't they doing that?" And I said, "Oh, my God, they're standing out there, they're looking up and down the hall and hollering, 'Hey, I need some help. Get some help!' "[7]

FRANK: My brother's been up there in #5 about four or five months now. His memory is gone, but his mind is—not bad. And I go up about five days a week in the morning. And probably Alice and David can tell more what's going on in the evening, because I don't go then. But he never complains about anything. He seems to accept what they give him. He could walk at first, but now he's in a wheelchair. His legs got stiff, and they used to walk him up and down the aisle, but he's almost ninety now. He really doesn't complain. He doesn't complain about the food ever. I don't know why, because he sure did at the hospital, so it must satisfy him somehow.

He needs help to go to the bathroom, he needs two people,[1] so he uses diapers.[6] That is so degrading to them, too, but for their own protection, you know. And they do not call it diapers; it's a dry-pot. The nurse said, "Diaper is a no-no, that is a dry-pot, and we don't want to hear that word said around here." They are disposable things.

CAROLYN: The Hospice people call these "the britches" and they don't seem to mind so much.

ALICE: I was wondering, in reference to the therapy, the physical *exercise*—I know when Elsie was there they used to have a routine in the morning where they had them out there, and they had them exercising their arms or picking their legs up. Those that were standing around were fine. It was a physical exercise routine that they did. And they swung their arms in circles and things like that. Now, Elsie did this. We now have nothing like that.[6] Elsie was the Nursing Director before this one here now.

My sister has been in bed so long that her legs are locked. They are in a locked position, like this. So when you turn her, she has to be turned like this. Now, the lady that's in the bed next to her is locked into the fetal position. Her knees are up. Now, if that lady dies, before they put her in the casket, they're going to have to break those legs, or something, you know, the bones in order to get them down. Because they are up. No rotation. No exercise. No movement.[3] And this is what I've heard; it's lack of motion.

Etta's skin is OK. The minute she gets something, I'm down their throats. I'm smearing and I'm rubbing every night, and I make sure of that.[9] If she needs anything—ointment—they're notified of that immediately, to call the doctor and get something.

DAVID: My wife gets up every morning. She gets up all day. She can sort of walk.

ALICE: Your brother's pretty well accepted there? He's eating good?

FRANK: He has sores on his rump from sitting in the wheelchair, but he has a kind of cushion they put in there.

HELEN: He had it there the other day. When the college gals were there, the student nurses, one of them had your brother out on the front porch in front of the building, and he was just really enjoying things. And he said (I don't know if it was true), he said, "This is the first time I've been outside since I've been here!" He was really enjoying that, and you know I do think little things like that, if they had the time—[1] There's no reason why they can't get those people out there. Outside. In the fresh air.

ISABEL: My mother's at #5 but she just ended up in the hospital last Monday afternoon, and she is still there, probably being dismissed tomorrow. It was dehydration. And I have been complaining to them.[8]

Lately, she has been taking ice water like mad. She would just reach for it. She hangs on it. She would drink and drink, and this is not like my mother at all. And I had been telling them. And one day I was in the room here, and this gal came in, and I said, "Doesn't my mother ever get any water around here?" "Oh, when she was walking she would go to the fountain and drink all the time." And I

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thought, "She didn't know enough to go the fountain from *day one* that she was in here!" This was the answer I got from her. But they are going to hear from me when she gets back—which is probably tomorrow.

She went in with dehydration[3] and urinary tract infection[3] and a little bit of pneumonia.[3] And now she will be on heart medicine, Digitalis. She's been in the hospital three times in five-and-a-half weeks. The first time it started out with gastritis apparently due to the arthritis medicine that she was taking. She was back out of the hospital for about six days, and she was right back in. Got out two days after Labor Day and ended up there last Monday again, so you know she was pretty weak and is still weak. The last time she ended up in a wheelchair; she was navigating on her own until then. But that was the last time she was able to walk on her own, and I doubt she will ever walk again. And I don't see why they cannot have water on the table at meals and see that they drink.[6]

FRANK: Well, I'd like to insert that they do have a water fountain here, but you can't drink out of it from a wheelchair.

ISABEL: And if you don't know enough to go and use the fountain you can't drink either.

FRANK: I think I'm going to see if I can't get that replaced and pay for it, because they make wheelchair-available drinking fountains now for handicapped people.

ALICE: Well, they do have tea out and ice, and you can get coffee.

ISABEL: But people that are confused cannot do so! And the majority are in wheelchairs. How many do you know over there that are not in wheelchairs? My Mom was one of the very few that was not in a wheelchair. I feel like Alice. It is very frustrating. And I've gotten used to a lot of it. You do; you have to live with it. There's no way around it. You have to live with it.

ALICE: Mary Johnson was in #5 and they put her on the stool, and Mary sat there for what she said was forty-five minutes, and the buzzer was going. I mean, her light was on and they didn't come and didn't come, and she just couldn't sit anymore. So she got up and she fell. She tried to get up and that's when she broke her hip.[3] She already was in a wheelchair. This was about six weeks ago and she's still in the hospital right now!

HELEN: My father is here at #5 and he has been there since about last February. When he first went in he could walk. He is very arthritic, and his hands are very crippled, and even when he first went in he couldn't do a lot of things for himself. He couldn't get his clothes off and on and that sort of thing. He *was* able to walk around, though, and this was a very big advantage for him. He got along pretty well as long as he was still mobile, but this last summer he has been in and out of the hospital three times, and he's down pretty good now. He's gotten his strength back to where he can get up in a wheelchair, since he's been back out of the hospital, but he was in for pneumonia and a bladder infection, and then he got back out. And the last time he fell. He was still able to walk around up until this last time of hospitalization. He was up in the night, at the rest home, and he fell. He didn't break any bones, but he hurt himself very bad. He was in a lot of pain with his back and his legs and his chest. They X-rayed him for broken bones and they didn't find anything except old fractures on his ribs that were in the healing process.

He had gotten up at night to go to the bathroom. You have to understand that he's very crippled even though he was still walking around. He used a cane and a wheelchair part of the time. He didn't ring for help because, as he says, "What good does it do?"[1]

Since I've had him back out of the hospital from the fall and he's been in bed mostly, I have been *very unhappy*. Because I will go in and he's lying there in a pool of urine.[6]

One of my biggest complaints about the place is the lack of personal cleanliness care that they give those people.[7] I've griped about that since he has been in, even when he was able to be up and around. I know that one bath a week is standard over there, and I've griped and griped and I finally got two baths a week. They said, "Well, you know if it's the doctor's order we have to do it." Well, the doctor ordered *three* baths a week, because he's so arthritic that the whirlpool would have been the only therapy he was getting anyway. But he's never gotten three baths a week. He gets two. But I go in every day and bathe him because I think that is terrible.[9] For anyone who is in bed like that all the time, two baths a week doesn't do it.

He's so crippled that he can't operate those lights they have over there. I've worked trying to get a string on there and a big round plastic ring, so that he can pull it down. But when he does turn it on he doesn't get results.[6] They have him on diuretics and laxatives every morning, and those people can't *wait* to go to the bathroom.

I mean, that light goes on and someone should be down there, but they aren't.[7] And so, it's been that way several times a day. When he first was in I'd go at least three times a day, sometimes four—and I always go twice a day.

DAVID: One interesting thing is that they all eat at the same time, and there's nobody out there to see the lights.[7]

ALICE: There's nobody at the nursing station. I believe they all eat after the patients.

DAVID: The lights go on and there's not one person; you cannot find one person. They're all eating together.[6]

VOICE: That's right.

VOICE: That's true.

KATHRYN: And if you go there and rap on the door and tell them what you want it makes them angry.[8]

HELEN: Since my father has been back from the hospital he still knows what's going on, which is bad. I think you would be better off if you had lost your mind before you had to go to one of these places. But it's very difficult because he does understand that he can't communicate, and they can't communicate with him either. It's a bad situation.

When Dad fell he hurt himself so it was unbearable for him to sit at all when he first got out of the hospital. He's gradually gotten better. I give him a little therapy

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every day. I bathe him.[9] I rub his legs and I rub his back.[9] I give him some motion there, and he gets that a couple of times a day, or I know he wouldn't be sitting up again.[9]

ISABEL: I met with the administrator one day and I said, "I see this every day, and I do this every day." And she says, "That needs to be corrected." So she found somebody there, some little nurse. That lasted about two weeks and that was the end of it. In my book, they can do better.[7]

HELEN: I found that out. I just go do it. I told the administrator, Nora, when I took my father back out there—I went to talk to her, and I said, "You just tell me what you're going to do. Just tell me what you're going to do so I can come in and take care of the rest of it, because I'm not going to leave Dad lying up there like that.[6] And Nora's been very hostile to me.[8]

DAVID: I don't think Nora has anything to do with the care, does she?

HELEN: Well, isn't she the head?

DAVID: She's just the manager. She just takes care of the money.[7]

ALICE: Reba, the Head Nurse, had her office locked up totally there for two or three days because she was working on the budget. Who does what up there, anyway? *Reba* was working on the budget.

Elsie had this problem so much when she was working as head nurse up there. She was doing so much of Nora's work it almost drove her crazy. [7] This is kind of one reason why Elsie had to get out. She said, "She's driving me crazy. I have to do all of her work besides my own—the paperwork that has to go in to the State." All this stuff, I mean, she had things to do, and yet she was still out there *with* the patients, like I said, doing those physical therapy exercises—stuff like that. You could *find* her! You could *see* her! With Reba, forget it! The door, like I said, is locked. You will not find her. You've got to knock on the door, and then they won't answer you—[8]

DAVID: I have tried to find her—

ALICE: I just push the damned thing open! She's already got some people in there, and I say, "Only one minute, one second. I'm just going to tell you this or that," and then I tell them what I want, and than I'll get out of there, you know. But you *have* to. She's not around. I don't even think she knows what the help is doing.[7]

FIRST VOICE: I've only *seen* that woman about once!

SECOND VOICE: What's she *doing*?

ALICE: God, I don't know. I don't think it's so much the help, the regular staff. God knows, the intention is there. There is no one that is purposely abuseful, or abusing these people. It's that they are not trained properly. They don't have a Head. They're all running in all directions. There is no supervision.[7] There is no one set way of doing things. And it's not done right. Because somebody at the Head does not know what they're doing.

BETTY: My mother is in #5. They get her up in the wheelchair and she can't sit by herself. They have to prop her up with pillows. And then she falls over and leans on that railing—the framework of the chair. Last winter I didn't come out here during the snowstorm, and when I did I found she had a big bruise about like this on her side where she had been leaning on the frame.[6] And it took over two weeks before it was cleared up. And also she has splints on her hands, and they used to leave them on at night. That happened to her during the snowstorm, too. She had put her hand on her cheek and she had a real deep scar here and bruise here. It was all over her face, almost to her ear and everything. *It* took over two weeks until it was all gone. I called the doctor and he said to leave the splints off at night.

And then about the food, just not very long ago I came out here and the food tray was sitting on the dresser, and the food was ice cold. So I took it back. And I met with one of these foreigners and I said, "The food is sitting in there and it is ice cold." And she said, "Well, we're busy answering lights."[1] So I took it to the kitchen to have it warmed up, and the cook told me that the tray went out at five o'clock, and I got there at a quarter after six. So an hour and fifteen minutes it had been sitting there. And the girl said, "We're answering lights." And I said, "You can't tell me you were answering lights for an hour and fifteen minutes solid. You should have had time." So when I went back after it was warmed up, she said, "Whenever it's cold I always go back and have it warmed up," and I said, "Maybe," because I didn't believe it. They don't want to go in and bother the cook too often.

DAVID: One of the foreigners is terrific. She is nice. She's sweet. She gets down and puts her arms around Sheila, you know. Of course, Sheila can't speak, but it just makes her feel so good.

BETTY: My mother has hardening of the arteries, and she is completely helpless. She understands everything, but she can't express herself.

Another one of these girls, she took the tray out (the cook told me this), she took the food tray out and in fifteen minutes she was back and she wrote on the chart, "Ate half of the meal." But she *couldn't* feed her in fifteen minutes, because my mother eats very slowly, and, too, it takes time to walk down to the hall and get her ready and then walk back again. And she couldn't do all that in fifteen minutes. It takes me forty-five minutes to feed her, but the girl wrote on the chart, "Ate half." She probably didn't even give her a spoonful.

ISABEL: Also the supervision in the dining area should be watched more closely, as Alice said. With the ones that are eating on their own, they'll eventually reach a point where they forget they're supposed to pick up a spoon and feed themselves. This happened to my mother. Her tray went back to the kitchen empty,[7] and my mother never got a bit of it. The man next to her was reaching over, and he ate everything out of there. And Mother kept dropping weight and getting thinner and thinner all the time, until somebody finally spotted it. It was Kathryn here that saw that my mother was not eating. That somebody else was eating her food.

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VOICE: Can you imagine that?

ISABEL: And all this time that woman was not getting anything to eat.

VOICE: They probably wrote down, "Ate everything." How do you like that one?

ALICE: I would go into the dining room, and they would bring the stuff out—like a hotdog, a big fat hotdog, or whatever—and these people, they can't cut it up. Their meat is in such big chunks. You let one of those pieces of meat get stuck in the throat and you know what you've got there. They're not getting a good breakfast. The silverware is wrapped up, you know, and they don't have enough sense to open that up to take the spoon out or the fork out. Or they try to eat with the fork something they should be scooping up with the spoon. It's little things like that. If someone would go around and watch![7] I've cut up so many a tray of food and stuff, and put the silverware in their hands, so that they could *get* at it.[9] After I get finished feeding Etta, I sit there in the dining room; and I'll have a cup of coffee and a cigarette, and I'll sit there and I'll *watch*. And you can just see how many of them—and, David, your wife's food half of the time is on her lap or on the floor.

DAVID: Absolutely. That's true.

ALICE: The other night I went over and gave her half a sandwich, because she could hold that in her hand.[9] And she ate her sandwich, drank her tea, and she didn't get any of the rest. The rest of her stuff was all over.

DAVID: They are cutting up her meat, her food for her now. They didn't do that until two weeks ago when I met with the people out there. She's a little hard to get along with. She wants to do everything for herself.

ALICE: But some of them do it for her, David. Some of them have fed her.

DAVID: That's right.

ALICE: And she's getting the food down. I've seen it. Some of them will help and she does not fight.

DAVID: She doesn't want to wear the bib, I know that, but her clothes are so *bad*. Now I just leave them there. I used to take them home.[9]

FIRST VOICE: You get so you can't *do* it any longer. It gets to be a problem.

SECOND VOICE: I still do Momma's laundry.[9] I've done that for five years.

ALICE: You've got a Nursing Director, and she should really be aware of these problems of feeding, and things like bedsores. But she's busy doing the administrator's paperwork.[7]

FIRST VOICE: That's right. She's working on the budget.

SECOND VOICE: Nora should be doing it, but *she's* doing it.

ALICE: Reba does not do her job like she should but she's not allowed to. I mean, she can't. Elsie was shackled the same way. She would bog down with all of Nora's work. She said, "If I could just do mine," she said, "it wouldn't be bad. But, God, I've got to do hers, too."

SARAH: I would like to add another comment. I don't have any relative, thank goodness, but I'm a retired nurse, and I am terribly disturbed by all of this. It *can* be helped! I have a friend over at #5, have for some time. And this poor care is just not *necessary*. And the care is done by aides who don't give a darn. They are there to get a paycheck. They don't care and they don't *know how!*[7] And if they don't have supervision they never *will* know. OK, now in *team* nursing, one person is made responsible for four people with supervision. Then they have something of their *own*.

And they take *care* of these four people. This one should be taken outside in his wheelchair—OK, see that it's done. Every two hours they should be looked after. She only has four people, so, it's her responsibility, under supervision, to see that they *are*. Four total, as they call them "total care patients". You have to break it down. If in her team she has two were lucid and good—you know, she wouldn't have too much care to watch them—and the other two totals, she might care for more. *But no more than four totals!*

How do I know? I've done this all my life! I'm a *nurse!* I've *taught* this kind of thing. And I've done it in the Army! I know what team nursing will do.

These terrible conditions are because of aides that don't care. They don't *care!* And it's one-to-one kind of care that we all want, and you want. It's a one-to-one care. Rubbing and turning and rubbing—that's *good care!* They don't know how to do it. They sit in a room, a whole bunch of them in a room drinking coffee and—a light's on—[7] "Well, I'm busy—" Why, that's not *care!*.

FIRST VOICE: At the top. There's something wrong at the top.

SECOND VOICE: They don't know. They don't care.

SARAH: That's right.

ALICE: You teach them how. I've seen them come out of school. I've seen them. They don't even know how to wipe *themselves*, much less wipe somebody else. Kathryn has had some; I've had some you have to show them, "You fix the bed this way." All right, on Etta, use the blow dryer (to get rid of all this rash she had from the enemas and stuff she had to use while she was in the hospital.) Let's see, you wash her down with a mild soap, then you use the blow dryer, then you put on the ointment or the cream, and we are going to get *rid* of that soreness that galled her on her bottom.

SARAH: Right!

ALICE: And these two girls had gone through school, had had their training—I'm working over there, and they said, "Is this it? Is this how you do that?" And I said, "That's how you do it."

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ISABEL: The Doctor says they do not have enough training. He says that the turnover in these homes is terrific.[2]

KATHRYN: It's training and all the people that really don't care to work. Those are the leftovers that work over there—that they can't get a job anywhere else.

ALICE: It's everyone for himself. Everybody for himself. Like I said, they waste more time running up and down the halls in and out of rooms looking for somebody to come and help them.[7] They are not a team. It is not a team effort. They had it for awhile. Like everything else, you go in and you bitch and you gripe. They say, "You're going to get what you want." You give it a few days and we're right back the same. Out the window! It's right back the same.

FIRST VOICE: Yeah, definitely.

SECOND VOICE: Absolutely.

SARAH: A good LPN could be the supervisor of several aides.

ALICE: They don't inspect.[7] They'll walk into a room. Is the pitcher sitting there? Or is the lid on the pitcher? Why don't they lift up the damn covers once in awhile and see what they're laying in, or look at their bottoms. Like, Johnny Kelly was lying out there—his testicles and penis were so swollen he couldn't even get his legs together anymore.[6] Tell me how in hell can an aide bathe that man down and not even see it?

FIRST VOICE: And not report it!

SECOND VOICE: Johnny died!

ALICE: I did report it. Yes, he died, God rest his soul, he's probably better off. And then Tom Carter, he was sitting there, his feet were so swollen he couldn't even get his carpet slippers on, and I told the girls, "My God, what's the matter with Tom's feet?" I said, "He needs medication for fluid build-up or congestive heart medicine, or something. His feet are so swollen[3]—" "Oh, again?" she said. "They were black and blue the last time."[6] And I said, "Oh, well, I thought I'd tell you." The next day they took Tom to the hospital. He wound up in intensive care, and a few days later he died.

SARAH: The state people don't turn the covers down and look at the bottoms.

ALICE: Why don't they lift up the sheets and see what they're lying in? Or a commode sitting in the room with urine in there. They're just not emptied. For several days, they're just not emptied.[6]

BETTY: Or the bedpans on the bathroom floor, on the dirty floor.[5] I've picked up many, many bedpans and washed them off and put them up.[9] Just about a week ago there was a bedpan on the floor and it still had something in it. They had emptied it but didn't clean it out. It was sitting in there, BM in it. And I went and got one of the LPN's and I told her, "So many times there's a bedpan on the floor." There's no shelf in there. All they have to do is put it up, but, no, they have to put it on the dirty floor. I told the LPN and she said, "Well, bedpans aren't exactly clean."[8] And I said, "No, but the floor is dirty. And they take the bedpan and put it on the resident's bed. And then they take the bedpan out and that person lies on that dirt."[7] I said, "I wasn't born yesterday."

ALICE: Betty's an old aide from way back.

BETTY: But when those State people come, if that door is closed, and *that* door is closed, "Well, this one looks real clean," and they'll check on it where the door is open. But I know for a fact that many of them never went into these rooms which are bad. I know that for a fact. They don't check that door if it's closed. It's closed because it's bad.

ALICE: Several weeks ago I complained to the State about the care in #5, and the State sent out one of their nurses. One of the first places she went to was right into my sister's room, so that was just obvious as the nose on your face that Alice was bitching to the State, you know. So, "Go out and look and see what kind of stuff Alice's sister is laying in." You know, "Satisfy Alice."

Etta's roommate, now, she doesn't talk. She's the one in the fetal position that doesn't get turned or anything.[6] All right, now, she's laying there, and this girl was feeding her. She's sitting there feeding her, "Winnie, open your mouth. How do you expect me to feed you if you're not going to open your mouth?"[8] The tone of voice was very rude, brusque. Well, I've been in there for three years feeding my sister, and I've seen them feeding Winnie. This was the first time that I had really seen *this*. Constant *hollering*. Winnie clamped her mouth so tight. She wasn't going to open it. And she just lay there, and I think that Winnie must have been scared to death. Now, Winnie, you get nothing out of her, I mean, you know. But I've been in there and I'll get a smile out of her. She'll smile, like that a little, you know, nod her head a little. So you get some reaction out of her.

But that aide, she hollered the *whole damned time* she was in there feeding her, she hollered at her, "I can't get her to eat. She won't eat. We'll give her liquids." So, they've got this syringe thing, you know, that milk and stuff was squirted in. And that was what Winnie got that night. "Well, she's just not going to eat," she took the tray and off she went. Well, I got so upset at that. I said, "Boy, never in my life have I seen anything like that." I was sitting *right in the room*, and she was hollering at Winnie like a little kid. "Open your mouth! Open your mouth!" I said, "What in the hell does she do to my sister, then, when I'm not there?"

This bothered me, so I let it out and they called her in. Then Reba asked me, "Did you see it?" I said, "You're damned right, I saw it!" Before that I would kind of—you hold back. You don't want to say too much because you do have family there. God knows they're trying. If you could do it any better you'd have them at home, you know. If you could handle it, you wouldn't have them there. They give you paperwork and things to read about guilt complexes about putting your parents or your loved ones in nursing homes. I *love* that part about a guilt complex. God knows we all have them. It isn't the guilt complex of having your parents in a nursing home, because actually when you do put them in there you are putting them in there with the

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explicit intention that you have no alternative, but that they're going to be taken care of. Your guilt complex comes from when you are there and you see that they're *not* being taken care of the way they should *That's what you feel guilty about!*

"My God, what did I do to my Momma; what did I do to my Dad; what did I do to Aunt So-and-So?" I put them in this home because I can't keep up with the care. And if you keep your mouth shut *you are condoning* the same things that you see!

ISABEL: Everytime my mom has been to the bathroom she has never, ever had her hands washed. I've never, ever seen an aide or a nurse wash her hands. I've told Nora that. When I took her to the bathroom, I washed her hands thoroughly.[9] And I've been there oftener than once as she was taken to the bathroom (she gets taken periodically throughout the day), and *never* have her hands been washed by any of the aides, unless they had a wet washrag there that they wiped her with and washed her hands without soap and so forth. That would be the only way, which is not proper. It takes soap and water. That is not enough. It is not enough.[7]

ALICE: I just wonder how many times do you find the food particles, how many times do you find the feces or excrement underneath the fingernails and in the crevices of the hand?[6]

ISABEL: That is the way they eat, ma'am! That is the way they are at the table, with their hands like that, if you're not there. And you can't always *be* there. You cannot *live* there. You have other obligations. You'd like to be there all the time, but you cannot be.

CAROLYN: I took the Reverend Father back to one of the rooms one time. This woman was there, and she said her mother was dying and she wanted Father to give his special blessing. And that room was so smelly—it was so dirty—and this little old lady (the woman's mother) kept moving this way and that way, she was swishing this way, you know, with her hands. So as we walked out I said to Father, "I don't know about you," (he had all wool garments on), "I don't know about you, but I smell like a bedpan." And he said, "I do too." So I went back in the room again to see why this room was in such bad shape. Well, this little woman had a bowel movement, and she's been playing with the BM.[6] The lady in the next bed told me this. I told the nurse and she said, "Think nothing of it." Well, I *did* think something of it.

ALICE: Have you seen times when they have taken it and it's been smeared all over the bed rails, on the walls, and not only that, into the mouth—?[6]

CAROLYN: I said, "This woman needs care." And the nurse said, "Think nothing of it. I'll take care of it." And I stood there for forty-five minutes and nobody goes into that room. The nurse was messing around with her paperwork.[7]

BETTY: About two weeks ago I got up there to #5 about twenty minutes until ten. I lifted up the covers and my mother was wet clear up to her neck, the sides, everything was wet.[6] So I took the blue pad out and it was heavy, so full of urine. It was so heavy that I threw it down on the floor and it just squashed. So I told the nurse, the LPN, "That's how I found her." I said, "I'll bet she wasn't changed all night." And she said, "Oh, yes, oh, yes, she was. I gave her liquid awhile ago, and I think that's what it's from." And I said, "No, it doesn't work that fast."

ISABEL: Now, my mother, we cannot keep her teeth in her mouth because she is so confused. I had a new partial made, and she had it one month and they were gone. And after that it got to the point that she couldn't follow instructions and couldn't have another impression made anyway.

Her food was supposed to be chopped; now it's supposed to be pureed like in a hospital. It would come (I'd be there) and there would be a piece of ham.[5] What happens when I'm not there? The next time would come maybe chicken with dressing, and the chicken was stringy pieces and the woman can't eat it.[5] She can't eat it, so she got no protein. Doctor P. said yesterday, "She's low on protein," and I said, "I don't doubt it."

ALICE: Potato chips is another thing. Giving them potato chips—

ISABEL: Before, I used to take her a candy bar so that she could keep weight on, you know, or I took her shakes, and I got so I took hamburger ground up, and I took things that I know she could eat—vegetables and fruits! This just happened recently, and she needs calories on her, and she needs protein.

I went to Nora with this. She said, "That needs to be corrected." This was about the food, I mean. She said, "This needs to be corrected." It *was* corrected for about two weeks, and then we're back in the *same thing*.

SARAH: Well, she didn't have it corrected.

BETTY: My mother had this bruise on her cheek and on her side, and I called Nora and she said, "Well, I'm not a nurse."[7] And I said, "Well, you can at least look at it."

VOICE: Not a nurse. That was some answer, wasn't it?

KATHRYN: I have an aunt in #6. One day we went down to #6, Carolyn and I, and I didn't see my aunt anyplace, and I looked for her. And I asked the nurse where she was, and they said, "She's wandering around. Just look in some of rooms. Maybe she went in there." So I looked and I couldn't find her anyplace.

CAROLYN: I told her to look for a toilet room. Maybe she was tied in there.

KATHRYN: She was tied on the stool in there.[6] We waited for awhile and she didn't come out, so I asked the nurse (I had ice cream with me to give her), so I asked one of the aides or the nurses or whatever she was, how long she would be in there. And she said, "Just a little while." Well, we waited thirty minutes—

CAROLYN: We waited more than thirty minutes.

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KATHRYN: And she didn't come out, and I asked, I said, "My ice cream is melting. Please take her out." And then we heard that "She's been sitting on the stool for at least an hour before you got there." Before we came. And she was half an hour while we were there! And we heard that was happening quite often down there.[6] This was just a few months ago.

And my friend was there the other day to visit her mother, Laura, and she said that they didn't even get her off of the stool while she was there. They had to visit with her while she was sitting on the stool.[6]

CAROLYN: Isn't there a state law against tying people like that? They should be watched instead.

MIXED VOICES: "Yes!", "Definitely".

KATHRYN: Oh, she was fighting to get off there! If she wasn't able to do anything in fifteen minutes, she wouldn't in an hour and a half. When the girls finally brought Laura off the stool the one said, "How is she? How is her butt now? Is it still so sore?" And my friend said, "Yes, very sore,"[6] and I spoke up and said, "My butt would be sore too if you left me in there for forty-five minutes."

VOICE: Yes, now isn't that right!

Excerpted from *Regulations for the Licensure and Operation of Adult Care Homes*, Kansas Department of Health and Environment, May, 1984.

28-39-86/87

28-39-86. HEALTH SERVICES.

The skilled nursing home and intermediate nursing care home shall provide organized health services with qualified personnel to meet the health needs of the residents and shall meet the health services requirements prescribed in K.A.R. 28-39-87 to K.A.R. 28-39-92 inclusive.

(Authorized by and implementing K.S.A. 39-932; effective May 1, 1982.)

28-39-87. HEALTH SERVICES: NURSING SERVICES STANDARD.

(a) Each facility shall provide programs and personnel to meet the nursing needs of the residents.

(b) **Supervision.**

(1) **Skilled nursing home facilities.** Immediate supervision of the nursing services staff shall be provided by a director of nursing services who is employed, full time, on the day shift. If the director of nursing services has other institutional responsibilities, a registered nurse shall be designated to serve as the assistant to the director and to act on behalf of the director during absences of the director.

(2) **Intermediate nursing care facilities.** Immediate supervision of the nursing services staff shall be provided by a health services supervisor who is employed, full time, on the day shift. If the health services supervisor has other institutional responsibilities, a licensed nurse shall be designated to serve as the assistant to the supervisor and to act on behalf of the supervisor during absences of the supervisor. When a licensed practical nurse serves as health services supervisor in an intermediate care facility, the facility shall arrange scheduled consultations with the registered nurse. The consultant shall assist in setting standards of nursing practice and in nursing staff development and shall provide consultation regarding nursing functions. The consultations shall take place in the facility and shall be provided for a minimum of four hours per week, during periods when the health services supervisor is on duty.

(3) The health services supervisor or director of nursing services shall have written administrative authority over, and responsibility and accountability for, the functions and activities of the nursing services staff.

(c) **Staffing.**

Each facility shall employ qualified personnel to ensure that resident needs are met 24 hours a day. The following requirements shall be met:

(1) Each facility shall provide, for each nursing unit, a registered nurse or licensed practical nurse on the day shift, seven days a week. The health services supervisor may be included to meet this requirement. In intermediate nursing care facilities, there shall be a licensed nurse on each shift for each nursing unit. A registered nurse shall be on duty during the day shift, seven days a week. If a licensed practical nurse is the only licensed nurse on duty during the evening or night shift, there shall be a registered nurse on call to assist if necessary.

(2) Nursing personnel shall be assigned duties consistent with their education and experience. All nurse aide trainees who provide direct, individual care to residents shall be under the direct, onsite supervision of a licensed nurse. Each nurse aide trainee shall complete requirements for and obtain certification as a nurse aide within six months of employment. Nursing personnel shall not be assigned housekeeping duties.

(3) Direct care personnel shall wear identification badges to distinguish among the different levels of staffing as follows:

(A) Each trainee enrolled in part I of the training program shall wear a badge imprinted with name

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and the title "Trainee: Level I."

(B) Each trainee who has completed part I of the training program shall wear a badge imprinted with name and the title "Trainee: Level II."

(C) Each person who has completed the requirements for certification shall wear a badge imprinted with name and the title "Certified Nurse Aide."

(D) Each aide certified to pass medications shall wear a badge imprinted with name and the title "Certified Medication Aide."

(E) Each licensed practical nurse shall wear a badge imprinted with name and the letters "LPN."

(F) Each professional nurse shall wear a badge imprinted with name and the letters "RN."

(4) Staffing schedules shall be maintained and kept on file in the facility for 12 months and shall include the hours actually worked and the classification of nursing personnel who work in each nursing unit on each shift.

(5) Personnel shall be immediately accessible to all residents to assure prompt, necessary action in case of injury, illness, fire, or other emergency.

(6) Direct, individual resident care shall be provided by nursing personnel, the activities director, and the social services designee in accordance with the following minimum requirements per resident per 24-hour period.

(A) Skilled nursing home facilities: A weekly average of 2.0 hours per resident per 24 hours and a daily average of not fewer than 1.85 hours during any 24-hour period.

(B) Intermediate nursing care facilities: A weekly average of 1.75 hours per resident per 24 hours and a daily average of not fewer than 1.60 hours.

(7) Two nursing personnel, one of whom shall be a licensed nurse or a certified medication aide, shall be on duty at all times. The ratio of nursing personnel to residents at no time shall be fewer than one nursing staff member for each 30 residents or for each fraction of that number of residents.

(8) The licensing agency may require an increase in the number of nursing personnel above minimum levels under certain circumstances, which may include location of residents, locations of nurses' stations, and the knowledge that residents' needs for welfare, health, and safety are not being met.

(d) Charge person.

At all times there shall be a charge person, designated by the health services supervisor or director of nursing, who shall be responsible for supervision of all nursing activities in the facility during the assigned shift. In skilled nursing home facilities, there shall be a charge nurse who is a registered nurse or licensed practical nurse for each shift. The health services supervisor or director of nursing may serve as a charge nurse in facilities with average daily occupancies of 60 residents or fewer.

(e) Restraints.

There shall be a signed physician's order for any restraint, including justification, type of restraint, and duration of application. A resident shall not be restrained unless, in the written opinion of the attending physician, it is required to prevent injury to the resident or to others and alternative measures have failed.

(f) Resident care and hygiene.

The facility shall provide supportive services to maintain the residents' comfort and hygiene as follows:

(1) Residents confined to bed shall receive a complete bath every other day or more often as needed.

(2) Incontinent residents shall be checked at least every two hours and shall be given partial baths and clean linens promptly when the bed or clothing is soiled.

(3) Pads shall be used to keep the resident dry and comfortable.

(4) Rubber, plastic, or other types of protectors shall be kept clean, completely covered, and not in direct contact with the resident.

(5) Soiled linen and clothing shall be removed immediately from the resident's room to prevent odors.

(6) There shall be available fresh water for all residents. For all nonambulatory residents, fresh water or other fluids shall be available at the bedside at all times unless fluids are restricted by physician's order.

(7) Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be taken to prevent dry, cracked lips.

(8) There shall be a written ongoing program for skin care implemented as follows:

(A) Bony prominences and weight-bearing parts, such as heels, elbows, and back, shall be bathed and given care frequently to prevent discomfort and the development of pressure sores.

(B) Treatment for pressure sores shall be given according to written physician's orders.

(C) The position of residents confined to bed shall be changed at least every two hours during the day and night.

(D) Residents shall be positioned in good body

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alignment.

(E) Precautions shall be taken to prevent foot drop in bed residents.

(g) **Oxygen.**

(1) Precautions shall be taken during administration of oxygen in the facility to ensure the safety of residents and staff.

(2) Oxygen shall be administered only upon the written order of the attending physician.

(3) The health services supervisor or director of nursing shall be responsible for ensuring that the staff administering oxygen are trained and competent to do so and that equipment is properly functioning.

(4) Oxygen shall be administered in private or semiprivate rooms only.

(5) A sign shall be posted on the corridor side of the door which reads "Oxygen—No Smoking."

(6) Before oxygen is put into use, all smoking materials, matches, lighters, or any item capable of causing a spark or flame shall be removed from the room.

(7) Oxygen containers shall be anchored to prevent them from tipping or falling over.

(h) **Supervision of resident nutrition.**

(1) Nursing personnel shall monitor food and fluid intake of residents and shall assist, when necessary, in the feeding of residents.

KINH News

Kansans for Improvement of Nursing Homes, Inc.
913 Tennessee, #2
Lawrence, Kansas 66044
913-842-3088

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SPECIAL SERIES

Vol. 1, No. 3 October 1985

INSIDE KANSAS NURSING HOMES

RE: NURSING HOME #7 NW

Number of nursing homes in this town: two

PHYLLIS: My mother's been in #7 four years. She's from chair to bed now. If you will support her, she can walk from the chair to the bed, but you don't dare trust her alone. She would fall. In some way or another, whether it is mental or physical, she has just lost that control. For a long time, you know, she could walk with support, your hand, just to balance her a little. They call it Alzheimer's Disease, that has set in. She knows what you say, but she can't talk. She was talking when she went out there. But this just eventually came on like everything else. Now for strength, she is as stout as a mule, but her attitude is on the reverse side. You tell her to lean forward, and she rears backwards. You go today, and she's this way. You go tomorrow, and it's another way. I've talked to the doctors about it. I wanted to take her to Kansas City. And they said we would just be wasting time and money. And she would be more of a vegetable than she already is. The care is good enough, according to the amount of help they have—the inexperienced help they have. I feel sorry for all of those young aides. It's quite a job for them. You just have to take into consideration, even if they are twenty years old, at this day and time, they never had the experience taking care of sick people like we did when we were kids. I tell you, with trying to tell anything about a nursing home, you are one person against the whole building.[8] If you want to talk to the administrator, there always has to be a witness, but *you* don't have one.

I don't complain anymore. I go out and do what I could do and then go home. And I keep her finger nails trimmed and her toenails trimmed.[9] And when I go out, I like to do for her and she likes it. There's days she rebels against me just like she does everybody else.

She was hospitalized once or twice for impaction. When you put her on the pot, she couldn't, or wouldn't do anything to help her bowels move.

You know one thing about all these homes. The people that runs 'em, they don't think anybody knows anything about 'em. If you try to tell them something, why they just look at you like "Well, where did you come from?"[8] And even with my mother, when they have new help come on out there, if I try to say something to them to make it easier to handle her or something, why, you would be surprised how they'll just back off, "Well, where did you come from?" I never thought that anybody gets so smart that they couldn't take a little advice from somebody else. I never thought anybody got smart enough out of a book that they could just walk in and handle it like they had experience for a hundred years.

They have an RN around the clock, night and day. It's a skilled home with inexperienced help. You know it is too bad that we had to live to be this old to find out what to expect out of old age.

You know what aggravates me? They'll get one or two aides and instead of giving them help, they will just work them to death.[7] Now, like if you had, in each hall, if they had one good aide and give her a little help, but they don't do that. They get two or three that are real good workers and do the work, and then they try to work them around the clock. They just work them to death. This is where I feel concerned for the aides. They don't want to give them time to do this job. It's just hurry, hurry, hurry and my God, I've walked into Mother's room and it was like a cyclone struck

About "Inside Kansas Nursing Homes"

This is the third Special Series KINH Newsletter which contains our report on the quality of nursing home care in Kansas as seen through the eyes of relatives and friends of nursing home patients. Frequent visitors to nursing homes are best able to observe actual day to day care; their comments are therefore deserving of our close attention.

We began our conversations with them in June, 1984. All comments presented in this Special Series have been taped and transcribed since that date. We talked with some individuals privately; we also held group meetings in several Kansas communities. We have edited the comments to omit mention of non-recent events or of any references which might pinpoint speakers or patients. All names of speakers, patients, and staff members have been changed.

Nursing homes discussed are identified by a number, arbitrarily assigned, and by geographical region: NW, NC, NE, SE, SC, and SW. For example: #3 NW. Nursing homes mentioned only in passing are assigned alphabetical letters. For example: Nursing Home A.

These conversations with relatives and friends of patients will be continued until we have received comments on at least forty to fifty percent of the total number of homes in the state (370).

Volume 1, of which this issue is Number 3, covers about 38 nursing homes. It will be published in serial form over the next few weeks.

Petey Cerf, Editor

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it. Things throwed here, things throwed there, stuff put here, her shoes under the bed and this and that and another—all these little complaints. But you can't blame the aides because they are only allowed so much time.[1]

A new aide will come on and just about the time she'll get to where she can handle patients and know what to do with them, they're gone and a new one is on.[2]

They look at you like you haven't got any right to say anything about your patient. They act like you haven't got any business, now you can believe this or not.[8] Oh, I'm suspicious of a lot of things, but then you can't talk about that. I've gone out there and her face, it would look like she had been hit in the face.[6] It was all black but you couldn't find nobody that knew why. You can find a bandage on her and you can't find out why that's there and you can take it off yourself but then you still don't know how it got there.[7]

What I told them about giving her medicine, I know you have to do it, if she gets to where you can't handle her, give her something, but don't give her enough so that she lays there like she is dead. That isn't necessary.

RE: NURSING HOME #8 NC

Number of nursing homes in this town: two

ABIGAIL: My sister, Dorothy, is at #8. I have a friend there, Ben. He is up and about and knows everything. His roommate is blind. So Ben puts Chuck to bed every night, because Chuck likes to go to bed right after supper, and if Ben doesn't put Chuck to bed every night they let Chuck sit up for a couple of hours, and he gets so tired he nearly falls over in his chair.[6] So Ben has worked out a plan, a way to put Chuck to bed. And Ben said, "If I didn't take care of Chuck, no one would."[9] This was his actual statement. And it's sad. Chuck uses the urinal, and I think Ben gets it for him and he set it beside him there. And that night it was there, and the next morning it was there.[5] So Ben emptied the urinal and cleaned it.[9] So my husband (who has had quite a lot of experience in nursing homes in this town) said, "Ben should take the urinal down and set it on the nurses' station." Which would be kind of a mean thing to do, but I believe it would get their attention.

There are not enough aides.[1] Not from five o'clock on. Some nights I've been there, there might be three aides there.

There are ten rooms empty on one hall. They cleaned out these rooms and moved all the people because they wanted to close those rooms off in order to save money. And this was very confusing to the residents. Some of those people had been there since they opened, and to move them to a new room! They were constantly going back to their old room, searching, and it was pitiful. It's been a month ago, maybe, since they did that.

I think occupancy is down because the price is up. Semi-private is forty-four dollars a day. All I know is that a friend has a private room at Nursing Home D, and it's a very small room, but it's adequate; and she told me that she paid a thousand dollars a month, but since then, they raised her two dollars a day which is still quite a bit less (about $35 a day) than #8.

At first, they bathed my sister only one time a week.[6] So then I was bathing her constantly.[9] She is wet all the time and needs a lot of baths.

I'm fighting the odor. I carry in aerosol sprays constantly trying to combat the odor. And it really gets bad sometimes. It's in the curtains. It's in the walls. It's everywhere, and there's just no way to clean it up without a total cleaning of the place.[5] Sometimes it's necessary to clean up her roommate, when they don't come for an hour, even though they have been told that the roommate needs to be cleaned up.[9] I have emptied bedpans, and I don't like to do it, but I don't like sitting there and looking at it either.

And I don't understand why aides are not given some sort of a disinfectant to work with. All they have is soap and water. I think this is an injustice to any person that has to work with another person that is not able to take care of themselves. I think they should be given a can of disinfectant spray to carry right with them. I have asked for their deodorant spray and used it. And it's watered down three-fourths, I would say. I don't know what it is, but it has absolutely no effect. So the last time they gave me some I poured it in the bedpan one night and emptied the bedpan for Dorothy's roommate,[9] and I requested that Dorothy be removed to another room after that experience. The roommate was becoming very hostile to Dorothy and to me and didn't want Dorothy in the room—or me—so we couldn't put up with that. So they moved her. Her new roommate goes to bed and sleeps all night and is out in a wheelchair in the daytime. No problem at all. So we're thankful for that.

EVELYN: I don't have anybody down there now, but my observation, when I did have somebody, was that it was kind of sad if the patient didn't have somebody locally to look after them, because I felt like they were very neglected.[6] Maybe their *needs* were taken care of, but not the little extra special things—clean clothes and things like that. The son or daughter lives in California or someplace else, why then, they don't look after them as well, if the person himself isn't competent to request it. Toward the end my father had to be fed, and you wondered if you didn't go down and do it once a day[9] if they actually got maybe two bites a meal or something. And that you don't know unless you went down and observed. But he was a good eater if you would sit with him and feed him.

ABIGAIL: Sometimes they'd have just one aide to feed maybe six or eight people.[1] And some of them couldn't swallow very well, and it *would* take a long time.

EVELYN: I always wondered about the water they'd set by the bed. My father didn't know enough to reach over and get a drink. So unless they gave him a drink—which I don't think they ever do—he never got any. Probably at his meals he got enough, but I'm just saying that they set things there and they don't offer them drinks.[3] Iced water and a container and a glass sitting there.

FRANCES: At times they didn't get fresh water for almost two days.[6]

ABIGAIL: Well, now the aide goes around in the evening with the juice. It's like sometimes eight o'clock in the evening, and last night Dorothy drank her entire glass of apple juice and enjoyed it. She was in the hospital eleven days

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with pneumonia. She wasn't able to take anything for awhile only with a tube. So we were giving her drops of water for awhile. By the way, she received excellent care in the hospital. I was grateful for that. But, I don't know, this water thing. I felt like, I've seen the aide go around with containers to all the rooms and have nice ice water sitting there where probably three-fourths of it wasn't used. I used to use it to wash bedpans.

The cleanliness varies. There are puddles on the floor.[3] You have to be very careful walking through. For awhile they were throwing all Dorothy's wet things on the chair. And then I would have to scrub the chair down and clean up all the wet articles and take them down to the laundry.[9]

GLADYS, R.N.: There is a cart for soiled laundry. The cart gets full and then they pile things on top, and then the odor becomes worse. I've seen the LPN's get after the aides to get those carts down to the laundry room after they have sat quite awhile. The aides need urging because they're tired. They're overworked. They're understaffed.[1] They're undereducated and underpaid. I think if they were paid better they would do more.

FRANCES: I am really concerned with the care of my aunt. She's in #8, too. At one time she could do more things for herself, but a year ago she had pneumonia and she's had urinary infections so that she is now incontinent. And she turns her light on, nobody comes. She's on diuretics—nobody comes. If they get there in a half hour that's *good*. If they get there in an hour that's a little better, but she waits *two hours* for the light to be answered.[6]

ABIGAIL: I've seen it happen.

FRANCES: I was over there one evening (she had another slight stroke in November) and it affected her good arm. She wasn't able to eat, so she had to be helped with her feeding. And I would go over at least once a day to feed her, sometimes more than that.[9] I went in one evening at five-thirty and she had her light on. She was wet. Nobody came. They brought her tray. I fed her. Nobody came to take care of her. Do you know at seven-thirty no one had answered that light? From five-thirty to seven-thirty![6] I stayed especially to see when they'd come. I walked down to the desk, and the nurse was sitting there daydreaming, and that light had been on for two hours.[7] And these aides, they are tied up with feeding from five-thirty to seven, and then *they* eat—and maybe for an hour they eat. And one *cannot* get them out of that room![7]

ABIGAIL: I stand in the hall anymore, and I can yell loudly enough that they can hear me down at the nurses' station, and they move. I've never understood why they don't stagger the aides' mealtimes. There's never anyone to answer the light during mealtime.[7] Half of them could eat for half an hour and then the other half eat for another half an hour, and that way someone would be on the floor all the time. I had a horrible experience one night. I went down and the fire doors were closed, and all these people in wheelchairs were lined up trying to get to their rooms. I took my sister through the fire doors and took her back to her room to get her ready for bed.[9] And then I asked why the fire doors were closed and they said they were having some problem with the system. So this went on and on and on, and those poor people were sitting there crying, wet, soiled, everything like that.[6] This has been a good six months ago, but I never forgot it. I kept going back to see if the doors were open, and they weren't, and finally some of the people who *had* been taken to their rooms were very upset and crying and going on. So I went down and I *opened* the doors.[9] I could see no reason for them to be closed—no one was working there! And I went to the desk, and I said, "If they don't get somebody in here immediately to take care of these residents, I'm going to call the police." And I meant it. And he just pointed to the door, and about that time the head nurse was coming. Then they all went to work. She got the girls out of wherever they were. The head nurse usually isn't there in the evenings. So this was unusual that she came in.

FRANCES: My aunt had urinary infections a couple of times.[3] These girls are always so busy when they *do* come to change the pad there on the bed, whenever they are ready to change the pad, they never think of washing the *patient*.[7]

GLADYS: Did you ever check to see if the bed was made *up* wet?

FRANCES: I've had that experience too. I've gone down and the bed was wet underneath. Maybe the pad on top was dry. So then I yank everything off clear to the mattress and throw it in the back and go get all clean linen.[9] But if the mattress is wet clear through there's no drying it.[7]

ABIGAIL: On Dorothy's, they have a plastic pad over, and I noticed that it even seeps through that and then the mattress is stained.

FRANCES: Now, one day they put my aunt up on the commode. They put her on the commode and say they'll be right back. They go off. . .

ABIGAIL: And leave her for an hour?

FRANCES: *Two* hours! *Three* hours! And her legs were bare. You know, over the edge of the commode. Her legs would be numb. They need more help. They *do* need more help.[1]

EVELYN: Well, I don't know if it is any different now, because I only go down once a week and I don't observe it every day, but when Dad was there it didn't matter what time of day I'd go, they'd all be in there having coffee. Is it still the same?

ABIGAIL: Yes, yes, coffee or pop.

EVELYN: Well, they're all *in* there, and it just didn't matter when.[7] I maybe hit it every time they were due a break. I don't know. But that irritated me. That, you know, there were people that needed *attention*. There were the few dedicated ones that maybe took their coffee and went on and did their work, but. . .

FRANCES: They have an awful big turnover[2] and yet there are those who have been there for a good many years. Some of them have been there since it's opened, some of

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them nine or ten years. And so you know that their salaries—when they start, when they are new, they work a certain time and they reach this plateau where that's all you're going to get—like say four dollars an hour. Well, the girls that have been there five, eight, ten years are getting four twenty-five. So they *are* getting just that much more than the new ones that come in. And then that (four twenty-five) is just as far as you go. I think that anyone who is satisfactory who works for eight or ten years for an institution should be eligible for a little more salary. I've had some of the good aides tell me they just get so disheartened they go home almost ill because they couldn't possibly do all the work that they were expected to do.[1]

ABIGAIL: I don't understand why eight hours a day they have, oh, fifteen or twenty cars down there of the people working there. At night you go down there and there are three cars. So why should all these people work during the day shift and then when five o'clock comes they walk out the door and a few take over. At times there's only been maybe two or three—for the 80 or 85 patients.[1]

FRANCES: I was just over there the other afternoon about three o'clock visiting my aunt. She was wet. So I went to look for someone. There was *one* aide on that wing![1] And this is the wing that has all of the wheelchair people, the people in bed, the ones that are incontinent and all that. *One* aide was taking care of them! And at four o'clock there was supposed to be help. But that girl was just beside herself. And at four o'clock you start getting them ready to go out to the dining room. They have to be cleaned and ready to get in their wheelchairs and go. But that type of situation for *one* person! There are twenty-four patients in that wing. When I'm there I do things for my aunt and I help them. Well then one girl will come in and say, "Well, I'll have to get some help." So then I'll say, "I'll help you." So I help change the pads and *I* wash the patients and they just go off.[9]

ABIGAIL: I do my sister's laundry at home, and Evelyn used to do her father's at home.[9]

When they put them to bed at night, if they would take them to the bathroom *before* they've slapped them into bed, how much work they would save.[7]

FRANCES: Do you know that my aunt, I would say, for the last month or so (she can feed herself but she has a hard time crushing her food), her teeth were not brushed *day after day*.[6] Finally, I would go over and brush them.[9]

I've been there with my aunt when the medication nurse comes in, and she hands me the medication to give her.[5]

ABIGAIL: Oh, yes, I've had that happen too.[5]

Last night, I took Dorothy down to the shower to give her a bath and here were two towels. Well, I needed more than that because they're these little limp towels. I like to wrap her up as fast as I can after I give her a shower, because she becomes cold quickly. So I went back to the room and got one of her big lap robes and wrapped her up in it after I bathed her. And I think probably I'd better do this from now on, because the towels are hard to find. Some nights there may be piles of towels and no washcloths![6] There's no consistency. Some nights there are plenty of sheets but no pads. I don't know why they don't wash all things at all times rather than just washing sheets at one time. I don't understand their procedure there at all.[7] I have even discovered some laundry people that cannot read. They cannot read the names on the clothing, so they don't get them back to the right room.

After reading about the Targeted Jobs Tax Credit Program, my husband and I discussed it. And the ones that we know down at the nursing home, we tried to think where they could find employment and all I could think of was maybe cleaning motel rooms. Even being a waitress—some of these, I couldn't see hiring them to be a waitress. But there is one girl down there who has a heart of gold. She has three young children, and I know she is scared to death she'll lose her job and she won't have any income at all. But the girl *is* undereducated. She is very kind to the residents, and she is big and she is strong. It takes a strong person to lift those residents, and I've seen many a girl aide down there lift a resident by herself, and I think there should be a law that two persons lift those residents.[1]

HELEN: I visit Nursing Home D once a week. I can understand everything that has been said here, because my husband was at Nursing Home D for nearly four years, but having been an aide myself and realizing the problems that they face, maybe in the area of incontinence, for instance, maybe you will just have that patient cleaned up, and you turn around and they are incontinent again. So I understand some of the problems that they face, especially since the homes are *all* understaffed.[1] But there are a number of aides who have been there for a number of years. And one little lady that has been a patient there since it began is high in her praise for the whole situation. She is not, of course, really alert now, but when she was, she would say she was thankful for the care that she got there, and the kindness that there was. And I see evidence of that all the time when I go out, once a week. I find a lot of positive things there.

ABIGAIL: For a while we had meetings of families who had patients at #8. One day I sat there and made a long list of all my problems, and the administrator took it and that was the last I saw of it. We have a lot of falls at #8. I don't know how many are related to lack of staffing. They take someone to the hospital every so often. I've walked in and someone will be on the floor, and the ambulance will come and take them to the hospital.[3] I've seen this happen, but I haven't actually seen the fall or what happened previous to the fall. When the new ownership took over they bought all those pretty pictures to put on the walls. Well, I bet there aren't even five people on that nursing hall that can appreciate those pictures. And they carpeted the hall that leads to the laundry, and the girls are very upset, because the carts are hard to push over a smooth floor, let alone with that carpet. So they fight that all the time. And also carpet absorbs more odor than anything, and the maintenance man said that it's going to be more difficult to keep all that carpet. One patient had to be moved because she couldn't run her wheelchair on it. They moved her to another room.

If one could open the doors without that buzzer coming on! I realize they have to have that in order to know that all the residents are inside, but ventilation! It seems to me that windows and doors should be opened periodically on a warm day to ventilate the place. I have been known to

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open windows and doors. #8 has a nice kind of a patio area out at the back, and I used to take my sister out there in the summer time. She loved to be outside. No one else ever went out there. Well, the door locks behind you when you go out. Then you are blocked from the nurses' station when you come back and beat on the door and try to get in. So you wait and wait until someone finally notices that there is someone outside. So I finally learned to put a towel in the door, and then we could get back in. Unless someone came along and took the towel out and closed the door. But they put a board fence around the area—solid board fence, and Dorothy would say, "Well, I can't see out." And I don't blame the people for not going out there. If it were a wire fence that they could see through, they would enjoy looking out. It's a nice open area with grass, and there is a little patio and some benches and chairs. But it isn't utilized because it isn't accessible. And, too, that fence bothered us, and I'm sure it would bother other people. Dorothy likes to look out—there's nice green fields, and fields beyond, and she always enjoyed looking at any growing thing. But one of the aides said, "We don't have time to take them."[7] And this is true. When they have to be wheeled out the aides don't have time to take them outside and supervise them. If they'd take about ten and one aide would stay with them, it looks like it would be adequate. They do have some of their lunches out there. They have what they call a barbecue, and I think they go out there and they probably have burgers or sloppy joes or something. And they do take a few of them out.

Some of them get out sometimes and wander around. We haven't had one get away for a long time, I don't believe. But they have had some that have wandered off and they had to search for them.

The food is horrible. My sister's is pureed, and that makes it quite sad. Have you ever seen pureed chicken livers? My sister wouldn't eat it and she eats most everything they serve. That particular night I was there and I said, "Really, girls, would you eat this?" And they all looked at it with disgust. And then the head of the kitchen came down, and she said, "Oh, we always have a choice. Your sister may have something else." I don't know what it was, but I didn't know they had another choice. But my sister cannot speak for herself. She talks a little, but she really isn't coherent most of the time. She would never say, "I don't like that," or "Please would you bring me something else." How many residents are able to say, "I don't want chicken livers. I want something else "?

FRANCES: They have scrambled eggs every morning. Now, look at all the cholesterol those poor old people are getting. Scrambled eggs every morning, and by the time they got them they looked green! They must not have been real eggs. They must have been powdered eggs, I guess.

ABIGAIL: I've been down there, and one night they had bread pudding and it was green.

FRANCES: My aunt said, "I cannot face those green scrambled eggs." And they were cold.

ABIGAIL: The head of the kitchen came back and said, "What is wrong with the bread pudding?" And I said, "It's green. Look at it" They were very apologetic. Ben, my friend, says that the food is horrible.

RE: NURSING HOME #9 NC

Number of nursing homes in this town: three

Charles did not know who was responsible for nursing home regulation.

CHARLES: My wife has been in #9 for two years; she is eighty-eight. She can't do anything for herself, and I can't begin to lift her and care for her—much to my regret.

The home is kept clean. The food lacks a lot to be desired. It is poorly prepared—lots of mixtures that hardly anyone eats but regardless those dishes are served again and again. Too, it may be burnt or undercooked. We do appreciate lots of fruit being served; however, many times it is tough, perhaps of low quality because of being picked green.

I spend many hours there each day to help Jane with her food,[9] because I love her beyond description, and to try to insure her getting the care she needs and deserves.

The old cry "short of help" is familiar.[1] That tends to be an excuse as well as a reason for so many conditions and situations.

Money spent for "attractive" things that meet the visitors' and public's eye should go for better pay and for help—for better quality care. Some of the help is *super*—very dedicated and compassionate and loving but they can't make up for the ones that *shirk*.

I can't understand why those of us who strive to pay for our own loved ones care are charged more than those of public status. We are also paying (through taxes) for those others, too.

There are not enough aides in the home,[1] and then there are some of them that just—well, I have made complaints about some. There are some fine conscientious ones. But, no, there aren't enough, and some of them just don't show up. And the conscientious ones are the ones that have to make up for those that aren't. We have some that I could just swear by.

It seems like there's quite a lot of turnover.[2] But there's one or two that's been there ever since it opened.

I've complained to the administrator, but I don't say anything anymore. I tried to at first, and I think some things have improved a little. But I do seem at the point where I just feel like they have it in for me because I am wanting something better all the time.[8] Maybe it's just me.

I like the head nurse quite well. She has more to do than she can do, and she doesn't have time to give you any personal attention, and maybe she doesn't have time to do whatever you ask her to.[1] But I think as a whole she's probably pretty good. She's on the day shift, but she comes in when they need her, on call, anytime at night.

About water, they used to keep her pitcher filled, but they don't any more.[9]

The home is clean. A thing I think is real bad, they take those people into the dining room at eleven o'clock, and it is about fifteen minutes after twelve before they get their food. They say the reason for that is that the help has to bring them in before they go for their lunch time, which is from eleven-thirty until twelve. There isn't any help on the floor then, because all the aides are in the dining room.[7] And they bring everybody, almost everybody that breathes, they bring to the dining room.

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I do worry about the patients with no family. I'm right there to battle for my wife and I see what goes on and what doesn't go on. And those poor people, I don't see anyone come to see them, unless they come when I'm not there.

Jane has gotten to the point where she is incontinent, and she gets so tired of sitting in that wheelchair. And there are times when she is in there from the time that they get them up in the morning at six or six-thirty, whenever they get them up in the morning, until she gets to bed after lunch.[5] And by then she is beside herself, and she is in a pretty sad state of affairs. And when I go up there and find it's time to go into the dining room and her chair is wet, why, I ask them to—of course, it's a lot of trouble. They have to take her out of the chair and put her back. And they just don't do that unless I'm there.[6]

I sometimes think that the more I do the more they expect me to do. They will say, "Have you washed her face? Have you cleaned her teeth?"[9]

I wish they would use the money that's spent for things that look good to the visitors and the families, for things like they need. Now, this administrator she is great for *show*. She has bought pictures to put in the dining room, and just so many things that take the eye. But the pads and everything are just rags.[5]

I do have this to say, that they do wash my wife, but most of them don't dry her.[6] And I have mentioned that to them. So, I think there is a lot of moisture that is left in there and that doesn't help her any. She gets a bath twice a week.

They're pretty short of help on weekends. Pretty short.[1] I always try to see that the bell was where she could reach it, but I don't think she does. I don't know whether her thinking is that alert or not. But I know that the bells ring, or are on an awful lot of the time up there, but they don't answer very well.[6]

RE: Nursing Home #10 NE

Number of nursing homes in this town: three

ROSE: My husband is a stroke victim. He entered #10 in 1984. He can't walk, but he does have some use of his right arm. He is incontinent. He is rational at times, but then at times he is irrational. He has never been violent or really hard to handle.

I feel like that, as for the most part, they are understaffed.[1] They are short of help so much of the time. The nurse will say, we had call-ins, or no-shows, and they always have excuses for it, but I oftentimes wonder if it's a planned situation, because of the amount of money they can save. Anyway, there's a question in my mind. This happens, well, about half the time.

The aides are always in a hurry! I've gone to the Break Room and asked them to come and help with whatever neded to be. They come after, you know, pausing to look at me like, "Well, you're taking away my break time."[8] One particular morning I was really upset. I happened to be there just as the girl was getting my husband up, and she did not wash him off. As I've said, he is incontinent. He had lain there wet most of the night, and she did not wash him off—did not wash his face—stuck him in clean clothes and put him in the wheelchair.[5] And I told her how unhappy I was about that, and she said, "Well, we're short of help. I just don't have time."[1] I said, "Well, maybe after breakfast, then, you can take him and give him a shower," and she passed that off. And so after breakfast awhile I waited around and waited around, and nothing happened. I walked back to where the Break Room was. There was five aides in there.[7] There was four of them sitting there. One of them was the Charge Nurse, and one was standing in the door, which made five of them. I walked up there and I said, "Would one of you busy ladies have time to come give my husband a shower?" Well, they all looked at me like they wished I'd drop dead.[8] And, finally, they did come.

The Director of Nurses was pretty unhappy with me to say that to *them*. She always says, "Come to *me*," though a lot of times she's not available. She's somewhere else, you know. She's a very busy person. Now, I don't say that she doesn't do much supervising, but she is a very *busy* person, and it's hard to catch up with her sometimes. She has been given more responsibility than the Director of Nurses should have.

Instead of coming in in the morning and speaking to my husband, "How are you this morning?", and this kind of thing, kind of getting him in a *good* mood, and just visiting a tiny bit, and taking a little bit of time to prepare him to get up, but they oftentimes are in such a hurry they just come in, jerk the covers down, say, "We're gettin' you up," and they stick him in some clothes and *up* he goes without any preliminary which would help a person start their day off. If he was dirty or soiled like that, they'd wash him off, but just getting him out of a *wet* bed sometimes, they don't feel like it's necessary to do anything. Or sometimes will just take a wet washcloth and swipe him off a little, which I do not call a bed bath and they'll put it down on the records as a bed bath.[5] My husband is seventy-five years old. He was raised up in a different age, where kids were taught to wash their face and comb their hair and be dressed to come to breakfast, and to *him* it's just not right. He doesn't feel good unless he has been washed, had his face and hands washed and his hair combed.

He has dentures, and oftentimes they won't even put his dentures in and take him to breakfast.[6] And he has had bacon before, French toast, different things like that, and no teeth to eat them with! And I've come there and found this after he had already eaten. I've said to the aides time and again, "You can't eat your breakfast with no teeth." That's their job.[7]

For the most part of the three months that he has been in the nursing home, I have been there three times a day. But not always since he has been able to feed himself. I would go at mealtimes, and help to feed feeders, but be close enough that I could keep an eye on him and see if he needs some help.[9]

The feeders just have to sit there and wait until the aides get to them. But their food sits there in front of them for maybe twenty minutes before an aide gets to them to feed them. The residents that are able to feed themselves, oftentimes are not able to cut up their meat. And I've said to the nurses, as I've noticed this, in a loud voice I've said, "How are these people supposed to eat their meat, pick it up in their fingers and chew it off like a dog?"[7] Nobody seems to have time to cut up their meat for them. There's never enough aides to do all these things.[1] And oftentimes the food is so dried out and tough, dry, or even cold by the time the nurses get to it.

My husband's water pitcher is not filled once a week

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even![3] One time the administrator happened to stop into the room, and I picked up the pitcher and I said, "No water, I'll have to go get some ice and water." And she said, "Well, you're supposed to have a clean pitcher and glass and ice water everyday." I just laughed and I said, "If we get that once a week we are lucky." So she said, "That's not necessary. I'll take care of that right away." She always shows a lot of indignation over these lacks, but still nothing happens.[7] Right at this moment, the pitcher is sitting in my husband's room empty and has been for a whole week.[3]

He has a retarded roommate, who is probably in his sixties. He cannot talk, or the only words he can say are, "Hi" and "Bye" and "No", and he is so neglected because he cannot make any demands on anyone.[6] He's a very good-natured soul that just wanders around. His denture cup, I have seen that when it had slime built up in the inside to where it would make you sick.[7] He drools and messes a lot on the floor, you know, like slobbery candy that someone might give him. He's not incontinent. He's able to get up and dress himself, and he also takes his pajamas and puts them in the drawer, and those same pajamas have been in that drawer for weeks and weeks and weeks.[7] They don't seem to be sending those to the laundry, or changing his underwear. Except about once a week, I guess, he gets a bath and maybe clean underwear then.

They allow him to sleep on top of the bedspread and he'll just sleep there on top of the bedspread and they don't bother to change it. I have *asked* them to change his bedspread because it would be so filthy, and I hated to walk into the room. I would say in my judgment he has a mentality of about a five year old or four year old, and he wants and needs mothering. He comes to me and wants praise for hanging up his bib on the doorknob. I always praise him.

He has a brother that lives in another town that does come to see him occasionally. And you know, the poor soul, he doesn't give anyone any trouble. He makes no demands, and he gets nothing. He's physically OK, just mentally retarded, as far as I know. I doubt that anyone has ever brushed his teeth.[6] He'll take them out once in awhile and run them under the faucet and leave an awful mess in the sink. And this is true with a lot of those that do not know anything. Their dentures aren't cleaned. They're just, you know, *slimy*, neglected in that way.[5]

Some of them that I feed wet themselves, and they're just not bathed often enough; and they just smell so bad sometimes I can hardly stand it.[6] One of the ladies in particular doesn't even know if she's alive or not, and she has such arthritic hands, which are just in claws, you know, into a ball. So I mentioned to the Director of Nursing one time about getting her fingernails trimmed. I said, "She grips her hands so tightly that those nails are cutting into her palm." I don't know whether she did anything about it or not. One woman has her own teeth but her gums are in poor shape. The aides, even, tell me that it almost makes them sick to see her because of the condition of her teeth in her mouth and the bleeding, and this kind of thing.[6]

This little lady that I talked about with the arthritic hands, I did ask one time if she got any pain medicine, because as I would feed her I would see her jerk with those little old hands and arms and whimper, as if she was in pain. But she can't speak and tell them.[6]

Another thing that bugs me so bad is them putting the men's shirts on them backwards and the ladies' robes on them backwards because it's more convenient. A lot of those arms are stiff or whatever. It's just plain handier for the aides to stick their shirts on them backwards and put the robes on them backwards, and away they go. It's dehumanizing, as far as I'm concerned. They did that to my husband a time or two, and when I found it I said to them, "I don't want to *ever* catch my husband's clothes on him backwards again." But unless the family or somebody raises Cain about it, nothing's going to be done about it.

Some of the wheelchairs don't have footrests, and the nurses oftentimes will grab two wheelchairs to take to the dining room—one patient going backwards, the other one forwards, and their feet dragging—and maybe get to the table with one bare foot, no house shoe, no stocking.[6] They go fast. They go so fast sometimes that those old people's heads are just bound to swim, you know, because they can't take that kind of thing.

At times, my husband is up by six o'clock, sitting there waiting for his meal. They start getting them up. They have a tremendous amount of wheelchair people.

As to falls, there are two people right now with head injuries.[3] I don't really know the cause of their falls, but my husband was dropped in the whirlpool because the hydraulic lift slipped off of whatever held it, or is supposed to hold it.[3] He fortunately was not injured, but he's scared to death of the whirlpool now. Immediately after this accident with him, they did get some kind of a lock that's supposed to hold that chair on there without any accidents. It should never have been without this lock. The people that fell are still in the home. They were never hospitalized. The lady that I spoke of fell about seven o'clock in the morning and just had an awful gash in her head, and she bled, oh, terrifically.[3] They didn't even notify her daughter until about one o'clock in the afternoon.[3] Her daughter is a school teacher, and as quickly as she could, she did come. They didn't take her to have her skull Xrayed until the next morning. They said after the Xray that it was a fracture.

And there is a man that just recently fell. The administrator told me that he just passed out. Now, he was in a private room, and they found him on the floor[3], and he still has a bandaged head. I don't know whether he was taken for Xrays, I don't really know.

What has bothered me is the patients' rights. There are many of the patients that are wheelchair and bedridden, you know, that do have a good mind. They're not confused for the most part. They will get them up in their chair, take them to their meal, and then leave them sit.[6] I have heard these patients cry and holler and holler and be in tears, "Please put me to bed. Please put me to bed. I do not feel like sitting up." And they'll say, "No, you can't go back to bed until after lunch," or "You can't go back to bed until after you've had your dinner."[6] At this age, hasn't the patient got the right if he wants to lay in bed and doesn't feel like sitting up for half a day? Haven't they got the right to go back to bed? Most of these patients are *old*. They have come to the point where sitting up, or those activities they force on them sometimes, like going to play bingo or going to listen to the music or watching TV, oftentimes they don't want to. I've heard a lady across the hall from my husband cry one morning when the aides were telling her she had to go to church. "But it isn't *my* church. I don't

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7. Inadequate supervision
8. Staff arrogance
9. Staff tasks performed by visitors
10. Prior knowledge of state inspections

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want to go to church. I don't feel like going to church." And they said, "Yes, you are. You are going to church. You go up there and go to church."[8] It was services held in the parlor. It seems kind of awful to me. If that person is in their right mind, she should have a *choice*.

My husband gets upset sometimes. Like I said, he is never violent or really mean, but he does get upset and cross sometimes because he does not have any choice. You know, they don't come in and say, "Would you like to get up now and get into your wheelchair?" It's always, "Well, we're going to get you up now." Or, "We're going to put you to bed now." Whatever it is they're going to do. Or, "We're going to take you for a bath now." It's never, "Would you like to have a bath now?" and let him say, "Oh, yes," or 'Oh, no."

He is a private pay patient. He has absolutely no choices on anything. And this is considered about the best home in our town. Only four blocks from my home, and I am there so much of the time. I can go at mealtime and oversee him, and go like I will shortly and I'll shave him and soak his swollen hands (his left hand is bad) and many other little things that he would like.[9] And then I come home. I am home for several hours maybe, and then if I feel the need or the urge, I run back.

The laundry is good. I would have to say that it is about as good as I have ever seen in a hospital or nursing home.

The food is very good at times and very bad sometimes, depending on who's in to cook that day. Sometimes the fish is so dry and hard that they cannot eat it. No sauce on it. One evening I was especially upset. I was feeding the feeders[9] and watching over my husband, and they had been served spaghetti with a meatball on top. It was just plain spaghetti with no sauce, nothing on it, absolutely nothing but a meatball sitting on top of it. And I happened to see the Administrator come in, and I motioned for her to come in to where I was at. She did, and I said, "I want you just to look around this dining room and see how many plates of spaghetti are just sitting there, left." The people, the walkers, had even gotten up and left the table and gone, because there was absolutely nothing on their spaghetti. And I said, "Not only is that a horrible waste of food, but those people haven't had anything to replace it." They just got up and left. She said, "Well, this is not going to happen no more," and all this. Like I said, you know, very indignant when you point out these things. Well, so far I haven't seen it happen again, but then, who knows?

Sometimes the eggs of a morning, they bake them, they don't fry them, and they're so tough that I can hardly cut them up. They cook them in the oven rather than trying to fry them in the skillet. They can do more of them at a time. And the eggs sometimes are just so leathery. I've heard that here they feed better. However, the quality of the food I would say is probably par for nursing homes. You know, the poorest quality, like, in vegetables. The peas, for instance, maybe there'd be all sizes of peas. They're actually factory rejects, you know. And there will be the overripe and the underripe all in the same bowl. I would say that it would be something that the canning people would not want to put their label on. They're probably canned up in large five-gallon buckets, or whatever. And a lot of these kinds of things I do see that are *poor* quality.

I have gone to my County Health Nurse and talked about the home. But the way I understand it, she cannot go in unless the SRS takes her with them. She can only just go to Topeka with it. To somebody in Topeka. I really don't know who, but I did complain to her about my husband's roommate, and how he was not cared for. I said, "Is there anything you can do about it?" I felt like I was butting in, you know. She assured me that I was not, and she asked me if I would like to talk to someone in Topeka about that. She even tried to put in the call, but the person was not there.

RE: Nursing Home #11 NE

Number of nursing homes in this town: two

Miriam Higgins did not know who regulates Kansas nursing Homes.

MIRIAM: My husband had a massive stroke paralyzing his right side. He was moved from the hospital for therapy. After he was admitted to #11 and settled, I left and came home about 3 p.m. He was completely paralyzed on his right side, not able to turn the nurses' light on or call for help. I went back at 11 a.m. the next day, found he had no water, the pitcher was empty and in the corner on a table.[6] He had not been turned.[6] They came in to get him up in a chair for lunch; he was dirty.[6] They drug him out of bed into a wheelchair, not cleaning him up. They took him to the dining room. After my feeding him,[9] they took him back to the room to put him to bed (dirty). I complained. Then they cleaned him up. I talked to the supervisor on duty. Told her the home had been so highly recommended, and this was the treatment they received! She had him moved to another hall where she said they got more care. I left to come home about 3 p.m. He seemed better when I went back Wednesday. He had some therapy before lunch. They brought him a fried steak, bowl of lettuce, and a peach unpeeled with the seed. He could not chew and hardly swallow. I found the dietician. She was so busy but did take time to talk to me. I asked if they couldn't send him blended food that he could tolerate. She did, but told the doctor I wanted him to have more calories.

Thursday they gave him a whirlpool bath and therapy, leaving him sit in the chair. He was so uncomfortable. They wanted him to sit up till after lunch, then promised to put him to bed. They just kept putting me off and putting me off about getting him to bed, because I knew he was real uncomfortable. He was completely paralyzed on his right side, and he kept taking his left hand and rubbing the back of his neck as best he could. ~~So I~~ rubbed it some for him, and then he'd take his left hand and put it on the seat of the chair and try to shift his weight. Well, after having all that therapy on the whirlpool, and occupational therapy and everything, I knew he was tired, because he wasn't used to that. I got there just before eleven o'clock, and it was one-thirty before they came in to put him to bed.

I even went up to the desk, and that nurse, she never even looked up.[8] It was two girls sitting there. The other one was typing and doing bookwork, and that girl at the desk, she just sat there. She never even looked up. She wasn't doing anything. She said, "Oh, they're just leaving him set up so he'll gain more strength. If he lays in bed all the time, he won't get any strength." I just wish that some official could go in there as a patient and be totally

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helpless and see how they like it. They kept coming to the door saying they'd be right back. This went on till 1:30. Finally two young men came in. One got hold under his arms, the other his feet, and with a swing like a sack of feed threw him on the bed.[6] Another therapist came in but could get no response; thinking he was tired and asleep he couldn't do much. I went home. About 8 p.m., I was called from the hospital saying he was in a coma and to come to the hospital. He passed away the next day. He had another massive stroke on the other side.

I am sure our doctor thought he was doing the right thing in sending him to #11.

I am deeply concerned about the bedfast people in that unit. If they'd leave one person dirty, no water, and food they can't tolerate, I'm sure they do others.

I deeply regret taking him to #11. When he got back to the hospital he had some pneumonia, infection and a very high fever, 105 degrees[3]—Maybe it would have been anyway. It makes me wonder if the people get what they are paying for and if #11 is living up to its name.

I didn't get to see the doctor's orders. The ones that we took out there, he had them sealed in a brown envelope and gave them to the driver. I would like to have seen the orders, because as long as he was out there I never saw any medication whatever. I fed my husband,[9] and I wondered all along if anybody would have fed him if I didn't. There was a older lady, they was feeding her, but they were so short of help they only had two aides on each floor, the way I understood it.[1] I had just as well have brought him home from the hospital. I wish now I had. That's what I was planning on doing. The VFW here was getting a wheelchair and a bed, and I had help to come. But the doctor explained that he wanted him to have therapy. And the physical therapist he was real good. And as far as I know the occupational therapist was. But the speech therapist—and that's what he wanted him to have mostly was, well, that was something else. They came in and evaluated him one day, and then, the next time (they just came, I think, three times a week), the main therapist the next time wasn't there, and the girl that came out, why she wasn't going to give him therapy that day, because she wouldn't be there the next time, and he'd have to get used to new faces all the time. I said, "Well, that's what we came out here for, and we're only going to be here twenty days, and what good is one therapy session going to do?" They were going to wait until the next Tuesday to get another therapy session. I said, "He'll only have one speech therapy in the twenty days that he would be here." I told our doctor, and he said, "Well, I need to know these things, because I send patients out there."

It bothered me an awful lot about the medication, because he was taking quite a bit there at the hospital. And they never took any blood pressure, or no temperature. No nothing. My mother's been in Nursing Home E in another town near us for many years, and they take hers two or three times a day, on every shift. They've got a chart they keep. And they would go in ever so often and take her temperature and her blood pressure, and they do when we're up there visiting. And they'll bring her medicine while we're there. Their food the last little while has been terrible, and it's cold when they get it. Of course, they have a big turnover in help.[2] It's low wages and so much work.

I'll tell you where a whole lot of it is, and that's efficiency. I worked here for ten years at the hospital as a cook. We made pretty near everything from scratch. But now they've got new supervisors and all these new girls, and they're getting so much of this prepared stuff. I told the woman in the office of #11, I said I was very disappointed in the care they got here, and I said it might be all right for anybody that can wait on themselves and push a button and get help. But I said for a helpless person, it's just no place for them. I know that I would never let any of my people go out there again. If I had brought him down here to the home nearer me, it would have been better than what he got up there. It would have only been seven miles for me to have gone, and I could have been there longer; I could have gone earlier in the morning and stayed later at night.

RE: Nursing Home #12 NE

Number of homes in this town: two

Jane Smith did not know who regulates Kansas nursing homes.

Excerpt from letter written by Jane Smith:

I visit my Uncle Joe in #12 NE every week, sometimes several times a week. He's been in #12 about three years.

Probably the thing causing us most trouble is the food. Let me say that they have the proper meal plans to show the inspectors *but* that is not what they prepare.

Often they have beans three times in two days. Wieners and beans or French fries for the evening meal is not on any bland, soft food, non-gas-producing diet I've ever seen! My uncle has a bleeding ulcer. Hamburger patties baked until they are hard and crisp-fried and French fries was another evening meal last week. Of course, there were other items on the menu, but perhaps not more than a dish of Jello. When my uncle came from the three-week hospital stay, the doctors sent detailed diet and care instructions. The dietician, when asked about the food, explained that they were on such a tight budget, they could not afford proper food.[5] So she went to Uncle Joe and told him not to eat what he should not eat. What was left for him to eat? Nothing but a little dessert. At $1000 a month I don't buy that!

Many of us who are years younger cannot eat such evening meals and not expect to be uncomfortable half the night.

Is there any reason soft moist meat loaves, moist well-cooked roasts, etc., or soft tender cooked meat in stews, or noodles, could not be prepared? Scrambled eggs are easily digested and eaten. Probably two-thirds of the patients have no teeth or at least poorly fitting plates.

Inexperienced help is part of the care problem. Usually only women with little education unable to work elsewhere are employed at the homes—any of them. A couple of months ago my Uncle Joe's ulcer started bleeding. The blood was being vomited. At 12:15 a.m., he knew he was in danger and called me. I called the doctor, who came and gave my uncle a shot which held him until morning, but his ulcer was still bleeding badly. About 8:30 a.m. they started getting him ready for the hospital. The nurses and aides had made no effort to call the doctor.[3] Why? He is ninety

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years old but his mind is very good, he is not ill otherwise.

He was in the hospital three weeks and had five transfusions.

Any ten-year-old child should have known to call the doctor.

As I contemplate a nursing home, being placed among so many people who have no minds would bother me most. It would seem that they could separate the "sheep from the goats" more than they do. I am not an unkind, uncaring person.

I do want to give this home an A+ for cleanliness. Never an odor, floors always shining, beds clean.

I think they *force*—yes, that's right, *force*—those able to sit in the main TV room to sit too long at a time, not knowing whether they are needing the restroom.[8] When one has arthritis your very bones ache after an hour or two. And many people really must go to the bathroom oftener than others and some days more than others.

To be told as you are attempting to rise "*SIT DOWN!*" is a little much.[8]

Additional Comments During Interview

JANE SMITH: They serve beans and wieners. Beans are not a suitable food for old people or for hardly anyone. And when they are perfectly quiet and have to go to bed an hour after they eat, it's wrong. And hamburgers that are so hard they can't chew them. Then when they have ulcers, they are not supposed to eat anything hard. I think they work hard in the morning and try to get a good dinner and they do have a good dinner everyday but in the evening they kind of let their hair down and it's whatever is easy.

I haven't complained to the staff about the food because if you get on them very often they just go out the back door when they see you coming in, and there's just no opportunity. It's not that home only, it's many of them. I think the suppers would be the chief complaint. They serve tremendously big breakfasts. They have egg and toast or egg and bacon and toast and they have cereal. And they have milk and coffee and stuff. And juice, of course. More than I eat in the morning. They've always had a good big breakfast. They get adequate food for breakfast.

As for other meals, they use so much of these ready-prepared potatoes, patties and things like that. They say they bake them all right, but when they do, they come out hard as rocks.

At times there certainly are not enough aides because, for one reason or another, they get fired or get mad or get sick and quit.[1] There are times when there are not nearly enough. And then last week, or in the last two or three weeks, they've had their hours cut. They got down on the number of patients, you know. People stay in those homes about so long and then they finally die. And in all the homes around, they have lost several patients this year. Not from neglect, I don't mean to insinuate that, but they have had serious illnesses. So when they got down to fewer people, they cut hours and some of the aides are only getting half time and some are two hours short. And people did not get good care.[1] But, there is always a nurse or a head person on duty there that can handle emergencies if they will.

I think the big reason why there isn't enough nurses and aides is because of the salaries. They start out at just the bare minimum and who in the world can keep a family on that? Only those who are uneducated or incompetent or whatever enough that can't get higher wages are the only ones that apply or else that have to have just a little bit of work to tide them over right here in the community. If they have any education at all or any get-up-and-go, most of them would be able to get better jobs. A thousand or more dollars a month for the care the residents get, and there's not enough money for good food and this, that and the other—I can't understand it. But the home is spotlessly clean. I've never smelled any odor in that building.

I haven't had any real big reason to complain recently. Not since my uncle's hospitalization. I found out that the less you complain the better off the patient is.[4] They get to hating you and you know they just don't like to be griped at all the time.

They are real good about giving them drinks. They come with juices and water and lots of times he has water all the time. Of course, there's water in his room. He can get water any time he wants. And they bring snacks and stuff like that, always in the afternoon whenever I'm there, and they do in the morning and sometimes in the evening.

The people who are able to get up and around they will sit two or three hours at a time and frankly I cannot do that. I have arthritis and if I sit more than an hour at a time my bones and joints are screaming and those poor old souls who are thin as can be, I don't see how they stand it. I've seen some of them get up, and I've seen them start somewhere, and I've heard the aides all over the building say "*SIT DOWN* there."[8] It is no way to treat people. Yes, you have to make them understand. And so many of them are hard of hearing it makes them yell it out so they can hear it. It makes it seem, to the rest of us anyway, that it is a kind of bullying attitude. But they just make them sit on those chairs for just hours at a time. I don't know how they can stand it.[6]

RE: Nursing Home #13 NE

Number of nursing homes in this town: one

Adelaide did not know who is responsible for nursing home regulation in Kansas.

ADELAIDE: My Aunt Elizabeth was in #13. She died a year ago. I still have two cousins in #13. I think one of their biggest things is their lack of physical therapy. One of my cousins had a broken hip; another one had a broken shoulder, and they just let them sit after they came back from the hospital. Evelyn, the one with the broken hip, had been there since '82 and Amy since '83. Evelyn, they restrain her at all times in a Geri chair by a harness, and this is why it's frustrating for her, because she can walk around, but they don't ever let her do that. They're supposed to exercise her every two hours but they don't.[6]

Evelyn is confused. She knows people and so on, but she's lost track of time. She's not oriented to time.

Amy has to have help to walk. That's why she's there, basically. She's ninety-six years old. She still is in her right mind and knows what's going on. But she sits in a chair all day, and then they're supposed to walk her to the dining room, but I think they've gotten in the habit of just taking her in a wheelchair.[6] And I think they leave her sit in the wheelchair and eat, which is terribly uncomfortable.

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Because those wheelchairs, they don't give them any kind of support other than to be just kind of flopped in a lump.

There are never enough aides.[1] And then the quality that they have. I mean, maybe this is typical of a lot of nursing homes, and i don't mean to put these people down. I think the majority of them are goodhearted and good workers. I think in many cases that they hire the kind of people that that's the only knd of job they can get. I think generally they are probably overworked, I guess. And the other thing that I always wonder about, they seem to all take their breaks at the same time, so here all of a sudden you've got twenty people sitting out there joking and having a great time. Which is all right, except that then there is no one in the halls to take care of this little old cousin that has to go to the bathroom too often.[7]

There is one RN there. Well, no, there's more than one RN, I guess, but there is one main one. And then they have three stations and sometimes there's—well, they go all the way from RN's to LPN's to whatever they call them.

In the case of my aunt who died, I think she was a victim of Alzheimer's disease, but she kept getting worse, of course. And it was very degrading how they let her be without physical, you know, personal care.[6] They would leave her dirty or wet.

She would be in a room—this was at my request—they let her be in her room, and then they had like a Dutch door, you know. But she'd turn off the heat, and I'd go in there and it would be freezing.[6] And they took the faucets off the sink, and she could never wash her hands. Well, that's another thing. They never have personal wash cloths and towels except my cousin who is in a private room. No soap, or anything, so their hygiene is atrocious.[3]

Then she did become sick and was running a temperature. This is one of my big criticisms of the nurses, that I feel that they just kind of ignore people.[7] Everything is all rosy until you call their attention, sometimes, to the fact that they are sick.[3] And then she died in a week after taking her to the hospital. But it was diagnosed as leukemia. That was about a year ago. She was in the home just about a year and a month. And then, too, as far as personal hygiene, they only bathe them once a week.[6] I don't know if this is something that is legal too.

Amy is incontinent sometimes. She is usually OK, but lots of times I've found her wet. She had stained clothing or something on.

Evelyn is not incontinent. She bugs them to death because she wants to go to the bathroom all the time. This is one of the things they're always fighting with her about. I think their policy now is to take them to the bathroom every two hours. And it isn't that they don't take her sometimes, but lots of times they'll park her down by the station, and then she'll have to get their attention.[6] And I'm sure that when I'm not around they'll ignore her even more. And sometimes when she can't even tell them that she wants to go to the bathroom. About drinks of water, particularly with Evelyn, they always have the liquid in her room, but it isn't that she can reach it.[6] They always say, when they take them to the hospital, that they're dehydrated. And then the nurse at the nursing home, she'll always argue with that and say, "Well, they always say that."

They are being bathed once a week. And they are sitting in these chairs all day, and sometimes their underclothing is stained, so you know it can be a problem.[6] After Evelyn had been in the nursing home probably a week or two, maybe three weeks then, *they* said that she untied herself and got out of bed and she fell in her room and broke her hip. They're very careful to get you to sign their no-fault form. It's quite detailed, and it's basically that nothing that ever happens is their fault![8]

I am Evelyn's conservator. Amy doesn't have one. Basically I signed the statement for both of them. I think it's for everyone that comes in. They demand that you sign. I know when Amy went, the one that operates on her own, she had this broken right shoulder, and they just *forced* her basically to sign it, because she couldn't really sign her name at the time she entered the home. I know they are supposed to act responsibly, but in any of these cases, of course, how do you prove what happened?

In the case of this Aunt Elizabeth that died, I'm sure she hadn't been feeling well for several days and the reason that she even got to the hospital was that she had fallen that night. And then the nurse argued with me that she didn't have a temperature,[8] but you get different ones. So I think she wasn't observant. My aunt had this red rash on her hands, and that was the only thing that the doctor would even admit her to the hospital under. I think that may have been a symptom of leukemia. So here this nurse had not even observed that. But I visited my aunt about every day. And I wasn't aware of it. I did notice she wasn't feeling well. In fact I had checked on her several times in that one day, just because I know they kind of let them slide.[6] And I've gone in and talked to the Director of Nursing, and she always promises everything, and she's real good at blowing you off, to put it simply. She'll listen to you, and then she thinks, "Well, now, she's got that off her chest."[8] She called me in after my aunt Elizabeth died, because she knew we were very upset, and we had already moved her things out of her room, because we were not going to take her back to that home. We were going to try to get her into this private care home at another county. So then the Director of Nursing called me in, and she wanted to know all the things that we were unhappy about. And I told her then. Then she would say, "Now, what can we do for your cousins?" Of course, they do their PR thing, because they don't want to lose their patients.

And another thing, it seems like when they first come in, many times they oversedate them, too. And I have fussed a lot about that and they would back down with the medication.

I worry about the patients with no relatives. Sometimes you'll see someone sitting there in a puddle, and they have one wing where the patients that need the most care, and are in the saddest shape, are, and I'm not down there very often. In fact, the one cousin, Evelyn, that broke the hip, they put her there in that wing when she first came back and I requested that, as soon as they could, to move her back up to another wing. Because the conditions are so horrible.[6] They've lost control of bladder. Everything on the floor and all that kind of thing. My cousin Evelyn is disoriented, that is confused, but she still has her dignity. She still knows what certain things are and she knows her family and that kind of thing. So she knows that she isn't treated like she should be. She also knows she's helpless to do anything about it.

The biggest problem, I think, for the welfare of the patient, is the lack of physical therapy. And then, otherwise it's just this general—I call it that they get really minimum care.[6] I think they just do the minimum.

This is another complaint: they keep the halls nice and shiny, but the rooms are not that clean.

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TAX CREDIT AND NURSING HOMES

Under present nursing home management policy, care of the patients is relegated almost entirely to aides, who work with little or no supervision by licensed nurses. For this reason, the kind of person whom nursing homes employ as aide is of paramount importance to the patients.

Present nursing home policy also dictates minimum wage, or barely above it, for this position. Obviously, better salaries would attract and hold better qualified individuals to care for our frail nursing home population.

What are the reasons which lie behind this established policy of very low salaries for aides?

One reason may well be the federal program known as the Targeted Jobs Tax Credit Program (TJTC).

Under this program, employers may qualify for a tax credit (dollar amounts to be subtracted from their federal income tax) of 50% on each targeted individual's first year wages and 25% of second year wages, on a wage base maximum of $6000 per year, if they hire persons from certain segments of the population.

TJTC is offered by the federal government to all profit-making businesses, presumably to encourage private sector employment of certain groups that have difficulty in obtaining employment. Economically disadvantaged persons aged 18 to 24 comprise one such group. The program defines income levels for program eligibility.

State agencies assist employers in qualifying for the tax credit by screening employees for eligibility and by performing the paper work required by the federal government.

Because of the tax credit allowed under TJTC, there exists a financial incentive to hire targeted group members in preference to other applicants perhaps better qualified or more experienced, who might deliver a better quality of care with a higher degree of efficiency and dependability.

Also, because the tax credit allowed is greater the first year of employment than the second (50% vs. 25%), there exists a financial incentive to limit the term of employment to not more than one year. This would affect the continuity of care. This is not an important factor with many service jobs, but is extremely important to providing adequate care to nursing home residents.

Nursing home management may find it mutually beneficial to control income levels by limiting the number of hours the employee is allowed to work whenever necessary to keep the individual in a targeted group. Then, if an aide leaves Nursing Home A at the end of a year's employment or sooner, and seeks employment at Nursing Home B, Nursing Home B will be eligible for first year credit. If that same individual returns to Nursing Home A at any time, Nursing Home A will again be eligible for first year credit.

If TJTC is exploited, it becomes harmful to the quality of care because targeted persons might be hired in preference to more qualified persons, and because motivation and continuity of care are affected by the low salaries, the controlled limitation of income and term of employment.

It also becomes harmful to the workers as it may encourage the maintenance of a sort of permanent slave class: workers who are never paid a decent wage, never offered seniority or merit pay, never have an opportunity for advancement, and are shuttled back and forth between various nursing homes, all of which are profiting greatly through TJTC.

Nursing homes are a peculiarly fertile field for TJTC exploitation because there is no apparent minimum standard for nursing home management hiring practices. Most patients are afraid or too ill to complain, if aides are incompetent or sadistic. And their relatives, if any, usually have the same fear of retaliation. Thus there are few "dissatisfied customers" to influence management practices.

TJTC terminates December 31, 1985, unless Congress extends it.

Those of us who wish to improve the quality of care hope either that it will not be extended, or that nursing homes will be exempted from the program.

If you are concerned about the effect of TJTC on nursing home care, you may write to:

1) The Hon. Nancy Landon Kassebaum
302 Russell Senate O.B.
Washington, D.C. 20070 Tel. (202) 224-4774

2) The Hon. Bob Dole
141 Hart Senate O.B.
Washington, D.C. 20510 Tel. (202) 224-6021

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SPECIAL SERIES

Vol. 1, No. 4 November 1985

INSIDE KANSAS NURSING HOMES

RE: Nursing Home #14 NE

Number of nursing homes in this town: over fifteen

The following letter, sent by Patricia to KINH, has been edited to change names.

My mother was admitted to the hospital in February, 1985, for tests. These tests revealed she had cancer of the colon for which our surgeon advised a colostomy be performed. Later, after surgery, he advised that she enter #14 while having radiation treatments at a nearby hospital. During her stay at #14, we were displeased:

—That they gave her a bath just prior to going for the treatments.

—That they would not put her to bed reasonably soon after coming back from radiation therapy.

—That they would not answer her call light for great lengths of time.[1]

We spoke to the administrator about these problems and she assured us that they would all be correctad. But only one was—a nice young man, one of the aides, did put her to bed as soon as possible each time she came back from therapy at the hospital.

We heard that when she had asked for a drink of water in the night, an aide had come in and said: "Lay down and shut up, you don't need any water"; and a friend at #14 told us, "That poor dear lady started to pray for a drink of water, but didn't get it."[6]

We complained about the service at #14 to the doctor who had recommended she be sent to the home, and he agreed that #14 does have its problems.

We looked for a better facility and we found it. We moved my mother there and she immediately started showing improvement and received care in a most caring manner.

Patricia sent her unedited letter to:

1) Ombudsman, Doris Stout
Kansas Department on Aging
610 West 10th Street
Topeka, KS 66612

2) State Rep. Ed C. Rolfs
House Chamber, Capitol Bldg
Topeka, KS 66612

3) State Rep. Jim Braden
House Chamber, Capitol Bldg
Topeka, KS 66612

4) State Sen. Merrill Werts
Senate Chamber, Capitol Building
Topeka, KS 66612

5) Mr. Arthur Cowan
Geary Co. Silver-Haired Legislator
536 West Chestnut Street
Junction City, KS 66441

6) Dept. of Health & Environment
Attn: Richard Morrisey
Forbes Field Bldg. #740
Topeka, KS 66620

7) Attorney General Robert Stephan
Capitol Building
Topeka, KS 66612

About "Inside Kansas Nursing Homes"

This is the fourth Special Series KINH Newsletter which contains our report on the quality of nursing home care in Kansas as seen through the eyes of relatives and friends of nursing home patients. Frequent visitors to nursing homes are best able to observe actual day to day care; their comments are therefore deserving of our close attention.

We began our conversations with them in June, 1984. All comments presented in this Special Series have been taped and transcribed since that date. We talked with some individuals privately; we also held group meetings in several Kansas communities. We have edited the comments to omit mention of non-recent events or of any references which might pinpoint speakers or patients. All names of speakers, patients, and staff members have been changed.

Nursing homes discussed are identified by a number, arbitrarily assigned, and by geographical region: NW, NC, NE, SE, SC, and SW. For example: #3 NW. Nursing homes mentioned only in passing are assigned alphabetical letters. For example: Nursing Home A.

These conversations with relatives and friends of patients will be continued until we have received comments on at least forty to fifty percent of the total number of homes in the state (370).

Volume 1, of which this issue is Number 4, covers about 38 nursing homes. It will be published in serial form over the next few weeks.

Petey Cerf, Editor

RE: Nursing Home #14 NE

Number of nursing homes in this town: over fifteen

GEORGE BAILEY: My mother was in nursing home #14 for about nine days, March, 1985. She was sent there for therapy following a stroke when her time in the hospital was up.

It's hard to say if there were enough aides. They mostly visited up at the nurses' station.[7] I don't know if they really worked if there would be enough or not. They were just lazy. And the lights were all on up and down the hall and people were trapped in bathrooms yelling for help.[6] Not all on, but there were a number of them every time I was there.

My mother is pretty much helpless. She is all paralyzed

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1. Understaffing
2. Turnover
3. Potentially life threatening
4. Fear of retaliation
5. Non-compliance with state regulations
6. Neglect and/or abuse
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10. Prior knowledge of state inspections

The Kansas Department of Health and Environment is responsible for nursing home regulation.

on the left side. She couldn't turn over or raise up in bed so that gives you a pretty good clue. She had a catheter.

They dislocated her shoulder jerking her around.[6] They parked her in wheelchairs and she couldn't sit up straight with her arthritis. It was very painful. They parked her in wheelchairs three or four hours at a time out of reach of the buzzer.[6] One night she finally told me she just begged them to put her back in bed because she hurt so much. And they said she had to stay up till after supper and she said she couldn't. She just couldn't stand it and so they threw her in bed and didn't give her any supper.[6] And that was, of course, knowing that she was a diabetic.[3] She of course can't skip meals. The woman in the next bed just cried when she told me. She said, "I felt so bad having my dinner and your mother didn't have any." And she developed a bed sore in nine days.[6]

She finally was so upset; they told me that with stroke patients that they tend to be depressed and they tend to cry and what you have to do is just change the subject. She was trying to tell me a lot of these things and of course her speech was affected but her mind wasn't. And her speech is better now, she could tell you more about this than I can. It was just a nightmare and she was so upset that her heart rate just went crazy. A friend of mine who was a doctor noticed it and he got her back to the hospital. Their records will show the dislocated shoulder. They found it the next day and the bedsore and all that.

I complained to the Administrator. She is trained in diffusing complaints and in making no changes.[8] I told her that. And I told her she should alert the Board and her lawyers and anybody else because as soon as I got mother situated that I was coming back.

RE: Nursing Home #14 NE

Number of nursing homes in this town: over fifteen

FREDERICK: My wife was in #14 several weeks ago. Evidently the staff that they had is not adequate enough. They seem to be understaffed.[1] It took a half an hour to an hour and one quarter, and I sat right there and timed them, and this is not only on one or two occasions but on a half a dozen or more, that they took that long in answering the patient's call for urination.[6] And then many times they come in and their first remark was, "Did you ring that bell? What do you want?"[8] And to me that is not the way to properly go in and address the patient. The conversation that is given to a patient is part of his care, you know. You can't talk to them just like you would somebody off the street. You have to talk to them with a little understanding because they need it. They are in there and they are under stress, you know, due to their illness.

They took her in by ambulance and they put her on the bed. And it was three and a half hours, three and a half hours now, I repeat that, before they came in and tried to put her in her proper dressing gown for #14. They use dressing gowns there. Or else the patient uses their own gowns, like my wife did. Three and a half hours before they'd done that, before they put water on her stand for her. She had a stroke and was paralyzed. Another thing that got me too, when she come in, and she wants something, like she would tell somebody, "Could you have a nurse come in here and do so and so for me?" The nurse would say, "Oh, that's all in her head, she don't need that," or something like that. Now that remark was overheard two or three times.

What my wife would do is, they would have a visitor next door, and she would ask one of the gentlemen if he would ask one of those nurses to come in because she already had punched the call bell and it had been a long time and no response.[7] And the nurse would say out in the hall on several occasions, "Well, that's all in her head," and "She don't need that."[8] Now, my wife did need a little extra care. She had a catheter in her and was paralyzed and it was hard for her to even sit up. And she still had to get her strength back. She really was beside herself because she was totally helpless and nobody would respond.[6] Then too, if they did get her up, the people that came on many occasions were not qualified to lift her up and put her in a wheelchair and take her to the bathroom.[6] They didn't do it right. My goodness, no.

And it seemed like they had quite a few different people.[2] They didn't have a regular scheduled staff, it didn't look like to me. My observation, now, they only had one nurse and the amount of patients that was on that floor, I don't believe they were properly served. Where these people come right out of the hospital, they need more care and they are not getting it.[7]

She was on Medicare for awhile. Her doctor came over himself and looked there one time, and I have a sneaking hunch that maybe he wanted to see firsthand himself, so he could form his own opinion of it too, besides seeing my wife over there for her medication and so forth. And those are our real complaints over there. Then when she was discharged from there, she had been there about two and a half weeks. They were supposed to send her to Center F, but the nurse didn't check on it and they gave the ambulance instructions to take her to Center G instead of Center F. And luckily I followed them and when they came to Center G, I told them, I said, "Hey fellas, what instructions did you have?" And they said, "Well, to bring her to Center G." Well, I said, "That's wrong. We are going to have to go to Center F." Now those things, I don't know, those things can happen anywhere, but it seems like a total addition of all the things that did happen doesn't spell a real organized care center that should be taking care of Medicare patients.[7]

The lady that was next to my wife, my goodness, she had cancer. And, my goodness, she couldn't eat a lot of the foods there and she kept asking for certain kinds of food. But they wouldn't give it to her. They just said, "That is the meal for today and that's it. Try a little of this and that."[8] And she would say, "I just can't eat that." A person that has cancer can't. Sometimes you have to give them a little special treatment on diet, but she sure couldn't get it there. And she would ring that bell and, why, it would be so long before they would take care of her.[6] And my, I just thought that was terrible. I thought that was the worst thing. At least my wife was alert. And the old lady you know, sometimes it is kind of hard for them to come out of a daze when they wake up and so forth, you know.

There was many rude remarks made, you know, by the help.[8] And when you put a person on a toilet seat and they had paralysis, usually it takes two of them to put them from the chair onto the toilet seat. Now that they didn't have.

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Very seldom, sometimes during the day when they had a little extra staff, to take the patient to clean them up and take them to therapy, sometimes they would have an extra one but the general rule was no.[1] And that also led me to believe that they are understaffed there. And really I think too that a couple of ladies, the nurses there, I think they have outlived their usefulness as far as their personalities are concerned. They are nil. And I know the difference between nurses and aides. I know very well. And I'm talking about nurses. Sometimes it is hard for those organizations to get a qualified nurse, with the right personality. I realize that. And sometimes they are well qualified as a *nurse* to give medication and all that, but as far as going in and *talking* to a patient I sometimes don't think they know all the tricks. They are not very sympathetic. And a lot of times when they come in to help a patient they complain all the time they are in there around the patient. "My goodness, I don't know why I have to do this here. *You* could do this yourself." This and that, you know.[8]

When she went to Center F, oh my, it was just the difference between morning and night. They were well staffed and my goodness, the people, they had a very proper way of coming into the room, greeting the patient, asking them what they wanted. And the minute that bell rang they usually, in just a few minutes, somebody was there to answer the call.

After she had been in the hospital so long, why they said she had to go. The doctor made arrangements for her to go to #14 because there wasn't an opening in Center F or Center G. So they sent her to #14 until there was an opening. And when she got to #14, I just wasn't happy with it, with their remarks,[8] with the way they took care of the patients.[7] I just wasn't happy with it. I think the first day when she laid there three and a half hours, I went back and I said, "Do you know my wife has been here three and a half hours now? I left her here, I went home and I come back, and she is still laying there like she was three and a half hours ago?" I said this to the nurse on duty. I said, "Aren't they going to do anything for her or get her ready for bed or anything?" I said, "My goodness, there is not even any water down there." It was in the afternoon, around four o'clock, I think. After I got her situated I went home, then I came back. I spent a lot of hours there. Now, after that, I kind of stirred them up a little. They sent one aide with the water and they came in and changed her clothes. You know when a patient comes in the hospital, the first thing they do is get down there and get them squared away. Most places. The nurse was very busy too. I had the understanding that it was understaffed. Yes, it was understaffed right there.

If there was a wrong doing in that nursing home right now, who do you contact immediately to have them rectify the problem? There is no central place that is not politically involved in the thing. Most places somebody can give direct action immediately.

The social worker there at #14, they call you together for a meeting wanting to know if everything's all right and why we are doing this or that, and then if you complain about one thing they are on the defensive. They're not listening to you to find something that they could make better in their home, they are there to offer their defense in case you have any complaints.[8]

The administrator is very nice and all that. I can't complain about that except that doesn't take care of the patients any better. And maybe sometimes too, they can't control everything under their thumbs.[7] Sometimes the people that they hire, they form cliques too, in the organization, and sometimes they have to be cleaned out entirely in order to rectify it.

RE: Nursing Home #14 NE

Nursing homes in this town: over fifteen

BETTY: My concern was about my sister really. She was in #14 NE with a broken hip and she was taken there from the hospital for therapy in December. My concern was that there just didn't seem to be any therapy. They would take her down to therapy and when I found that she didn't know how to get up out of the chair and how to use the walker then I asked would it be possible for me to watch them give her the therapy. They would take her down to therapy and help her out of the wheelchair. But what I'm saying is I don't know what they did after that. When we took her home after the twentieth day, she didn't know how to use the walker. She could get up out of the chair with help, but with the walker she seemed to be just lost, really. She didn't know how to back up to a chair and sit down and my concern was, what was the therapy for. Because when I went down Monday with her, they told me I wasn't supposed to stay, they would rather I didn't stay, because they wanted her to know how to get up and how to use the walker before any member of the family saw this.[8] To this day the things that she's learned, I taught her myself. Because she didn't know how to get down those two steps nor to get back up. And that has been quite some time ago. So I wanted to know about that.

Then, the next thing that happened was the fact that when she was there they get the people up. They have to get them up, I'm not complaining about that. But my complaint is that when they put those people in the chair, and I know it takes them a while to get back to them, with the many people they have to attend to,[1] they should put them where they would be able to get help. Now we would go there different times of day, not only I did this, my other sister and other members of my family would go. And she would be away from the bell where she could not reach it regardless of what would happen, she would not be able to reach it.[6] And then we would find her crying, saying she had to go to the bathroom or had to use the bedpan, whichever the case may be, but she was not able to notify anyone because the fact was she was away from the bell.[6] They didn't teach her how to unlock that chair and get over to there, or she didn't do it, or something. And she's not what you'd call senile.

Then I had the feeling that there was not enough privacy. The lady in the next bed had had some problems and she also had a decubitus ulcer that was really bad. Okay. Here's our family over here or our friends, whatever, and they're over there working on her. Sometimes the curtain would be all the way, depending, and sometimes not.[5] All right, the ulcer was on her backside. To me that wasn't the way. It's against regulations. I had the feeling, now my sister did not tell me this so I can't say she did, but my family had the feeling there had been some kind of nastiness going on because when we would get there and we would try to say, "Why didn't you call the nurse?" my sister would cry. Now, my sister had never been afraid of

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anyone. And so there was no reason for her to cry and not want to call the nurse.

And they have some dignity left regardless. And I guess my concern is that maybe all too soon I'll be in one of those places and I most certainly don't like a lot of the things I see.

What I think happens when they know they are going to be inspected, they can shape up and get everything clean and in tip-top shape.[10] But if they didn't know, there would be a lot of things that would not be in tip-top shape.

RE: Nursing Home #14 NE

Number of nursing homes in this town: over fifteen

Ruth did not know who regulates Kansas nursing homes.

RUTH: My father was admitted to #14 a few months ago. He was recovering from a colostomy. He was sent there from the hospital.

There were a lot of things that we were a little concerned about. The first 24 hours that he was there he didn't have any water to drink, in his pitcher.[6] They seemed to consistently be short-staffed and so he often would ring his bell and have to wait a *long* time to get a response.[1] At one point, at least one time and probably several times, when they would change his sheets and work with him or something, they would move his urinal out of his reach. So then when he would need to reach it and he couldn't, he would call, ring the bell and no one would come and no one would come, and no one would come.[6] So he would do what he would have to do. The aide at least once told him that "You should have better control! You will just have to lay in those wet sheets for awhile."[8]

And because he was a colostomy patient, occasionally he would roll over or whatever in his sleep and burst his bag. And they didn't come check on him very often. And so he would have to lay there for a long time. You know, even if he was asleep he would lay there for a long time in his mess.[6]

While Dad was there, because he has very, very poor circulation, his feet were supposed to be kept propped up on some pillows. And his legs, so they could heal, shouldn't touch the bed. But he could not rearrange the pillow when he needed to, so if the pillow slipped or something, he'd be without his feet propped up. And he developed bedsores. They were pretty bad after two weeks. Then we had discovered that he had not been getting up for therapy. They hadn't been making him get up to walk, or for physical therapy. And the doctor had ordered therapy. But apparently it may not have been entirely their fault. Dad would say, "I am just so tired, I don't want to do it." I can't completely absolve them because even if the patient—well, it is not unusual for the patient to be tired and not want to, but somebody needs to motivate that patient to get up and get well. I do know that from the last time Dad was up in a wheelchair, until we took him home, it was about three weeks. He was in bed and not out of bed all that time.[7]

I was in one day and I noted that his sheets were very, very dirty. They were using Betadine on his sores and that leaves a stain on his sheet. I noticed that one corner of his sheet had pulled off the bed and there was just bare mattress there, so I pulled that sheet down and pulled it back over the bed and noticed the stain when I did that. I was really surprised when two days later, the sheets seemed to have the very same stain pattern.[6]

Dad came home after three weeks, because we decided he could lay in bed at home more cheaply than he could lay in bed at #14, and we thought that we could probably care for him at least as well if not better. And I think we did, at home; but we hadn't understood before that that was an option. But when he first left the hospital, he was still so weak that we probably couldn't have cared for him. Plus, my mom is a stroke victim. My mom had a stroke a few years ago, so she is not real strong. My father is seventy-two and my mother is sixty-eight and she is a very small person, so it didn't occur to us at first that he could be cared for at home. And we thought he was going to the nursing home to get better, to get physical therapy on a regular basis. This would be the kind of treatment that would be rather hard to do at home.

My uncle was in to visit him while he was in #14 and he did comment that Dad was laying on a completely bare bed. No sheets at all. It was very embarrassing because my aunt was with my uncle and Dad wanted to kill himself. He had that hospital gown on, and you know how you can get twisted around in those. They just hadn't gotten around to putting the new sheets on yet. That is the time when he should have been gotten up and put in the wheelchair.[7] He lay on that bare bed for a whole day, he said.

I complained to the doctor about the care, and Mom says that she several times complained to the staff. At that time, who we should complain to, that was never clear to my parents. I had some written material but it never said, "If you have a problem, contact. . . " or procedure or that sort of thing. Nor are people of that age inclined to question the medical care or complain. At least, if my folks are representative, they feel that the doctors know best and whatever the doctor says goes. And I do not think that my parents are unusual in thinking that these are highly skilled professionals that they are dealing with. So they expect that they are getting what is the right thing at every point. And I know when I told Mom that she ought to call that to someone's attention, she said, "Oh, they must have a reason for that." I think that is a common attitude; and I think it is an attitude that people in the nursing home industry in general and in the health care field in general probably don't understand. We have a whole generation of people like my parents who are not going to ask questions, who are not going to complain.

RE: Nursing Homes #14, #15, #16, #17, & #18 NE

Number of nursing homes in this town: over fifteen

MARY: I just get so tired of going to these nursing homes and finding people that are not cared for. You know, their bed is wet. What I find most is neglect.[6] I find #14 to be the worst because maybe it is the largest and I see more patients there. But going week after week, the biggest thing there I find is neglect. The patients are thirsty. They need to go to the bathroom. You go to get them to take them for services and you have to go down and get a nurse from the station to bring them into the bathroom and if we don't go down and do it, they say nobody would do it for

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them. They would just have to sit until the aides get finished with whatever—their coffee break or whatever they happen to be doing.[7]

There was a woman over there who wanted to make a complaint when her husband was there but she was afraid to, because they would take it out on her husband.[4] Lack of care. Not enough attention. There is another lady I go to see and she said she has heard the aides go down the hall and say, "Don't go into her room" or "Just tiptoe past her room, because if you go in there she will want you to do something for her." It is that type of thing and it just galls me.

I go to #14 one afternoon a week. I'm usually there an hour to two hours. Our church has a service there, and I visit the rooms individually of those who can't come. You go to some room to visit somebody and there is somebody sitting there with urine on the floor. It smells to high heaven.[6]

And the food, one lady told me, she said, "We used to play a game, you know, to kind of guess what we were eating." And another lady is diabetic and they expect her to eat all the same foods that everybody else eats.[3] And the lady who wanted to make a complaint said her husband woke up in the night and his roommate had slipped somehow and his head was down between the end of the mattress and the foot of the bed, and he just laid there all night. Nobody came to take care of the man.[7]

The price they pay does not equal the care they get. That's for sure, and I think probably in all of them. But there is one that I go to where they are getting the best care, in Nursing Home H. I just sort of like that little place. It's homey.

Another home that I think needs some attention is #15. I know we had some people from church that took things out there at Christmas time, and they said they were treated very rudely.[8] They are not for sure if the patients even got what they sent out. They saw them put the things on a shelf in a closet someplace. It could be they used them later, you know.

And I go to #16. You see the same things there. It is kind of universal. The neglect and the smell.[6] Now, to me, #16 smells the worst.

Then out at #17, a lady said to me one day—and this happened a couple of times—she said, "Oh, dear," and she was apologizing for the odor. And they had given her a suppository and she was waiting and waiting for them to come. And they didn't come and so she had to soil the bed. And she said it happens all the time.[6]

Those people wouldn't be there if they didn't have to be. I really feel some of those aides are up there for the money and I think that's all.

I visit #18, too. The odor is really pretty bad up there and one of the people that I visit there, this man's wife complains a lot, (and I've gotten this at several other homes) about the thievery that goes on. Her husband's wheelchair was almost taken off. She says they are always getting something stolen. They took his electric razor once and all sorts of things. It is the same everyplace.

RE: Nursing Homes #19 and #20 NE

Number of nursing homes in this town: two

ALTHEA: It's kind of hard to know where to start. We got really involved in this in August, 1984. At the time my father, Jimmy Clark, was in #19 and also my mother-in-law. My father has since died, but I'd actually been keeping kind of a little record of incidents.

In August we got a call at one o'clock one day that my mother-in-law had fallen that morning at ten to seven. The doctor hadn't been called. They didn't know why she fell.[7] She hadn't been to the table. She had been in bed ever since it happened with a shoulder complaint.

I wrote a letter to the person in Topeka that was supposed to be responsible for this home. He called me right away, the man who was the Regional Director for the company that owns this nursing home. We set up a conference for the next week, and I had a list of items that we had determined were a problem.

Excerpted from list of items:

Jimmy related how girl who came to get him up this a.m. had jerked him up with his right arm. Without support he fell over. She told him as she sat him up again that if he fell down again, she would just leave him there.[6]

Received medicine bill from drug store. Noticed a new RX number, called drug store, said medicine had been prescribed for a urinary tract infection for Jimmy. *No one* had advised me that he had a urinary infection. At that time medicine was in last day. I asked if a urinalysis would be done and everyone I asked at the desk seemed to be surprised that one was necessary. The nurse advised me that Jimmy's doctor was sending the lab person to do a urinalysis for Jimmy and that they would advise me of the results. That was four weeks ago. We have had no report of the results of the urinalysis.

Jimmy regularly reports that no one answers his bell, consequently the bed is wet or soiled.[6]

About middle of July, no one answered bell on 11-7 shift, consequently b.m. in bed. when I arrived at 9:30 a.m., dirty rags used to clean up b.m. were still lying on the night stand.[7]

Told Health Services Supervisor and she said that she just couldn't do everything. Would tell somebody about it.[7]

Jimmy can't use bathroom in his room as it is not equipped with railings and even if it was, roommate with colostomy must have use of bathroom for several hours. He is taken to men's bathroom down the hall and left for hour or more as no one will come to answer the bell.[1]

Many mornings employees who apparently have not had adequate instructions will come to Jimmy's room, get out his clothes and *tell him to get dressed!* He had not been able to dress himself nor even get out of bed without assistance for the last five years.[7]

Jimmy is also unable to zip up his pants after using urinal, so his abdomen is exposed most of the day as no one seems to have the time to be concerned with assisting with the zipper.[6]

When I arrived at #19 about 9:00 a.m. on this day, I could see that Jimmy had suffered some sort of stroke. None of the personnel had noticed he was considerably more paralyzed, not speaking at all well. I had to call it to their attention.[7] Then, he fell out of the chair several times

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before they decided restraints should be used.

Spoke to the Administrator after having been in on Saturday p.m. when odor was so bad that it was nauseating. Had visiting relatives who were really not too impressed with those conditions.

Many days, my mother-in-law, Priscilla, and her roommate tell me that their beds do not get made until noon and they have to sit there with the mess. Very embarrassing when they have friends stop by.[1]

Jimmy having constant problem with bowels and when asked what fresh fruit they were having, he said, "Non Upon asking Health Services Supervisor about th problem, she reported that they bring this to the dietary department but the cook tells them that their food budget is so low, they have no funds for fruit.[8]

No incentives for employees to do a good job as after several years, pay is only a few cents more.

We started through these one at a time. After the first three, I think, he said, "Well, I can see that there is an underlying issue here, and I don't know what it is, but there is some problem here that you're not saying." And I said, "What are you talking about?" He said, "There's usually some underlying issue that's bringing you to complain."

And we said, "These are the complaints, right here." And then he started accusing us of being guilty for having placed our parents in the home.[8] And we said, "This is not true, because they all went voluntarily." There were three of them at one time—my in-laws, and my father. And then—he didn't mention this next item—but then in his response in a letter after the meeting, he wrote and he started over again and said that these two items were the reasons that people were unhappy with the people being in the nursing home. Number one, he said, they felt guilty about having placed them in there, and number two, because of financial burdens.[8] So I told him in a letter that neither of these facts was true, and that, you know, it was not an issue at all. My father and my in-laws all were paying for themselves. There was no burden on us.

So then I wrote to the Kansas Board of Health and Environment (another nursing home operator had told me I should write to them). I sent them *everything*. I sent them a complete listing of all the complaints, the letters that I had written to the Regional Manager of this nursing home chain and his replies. And I haven't heard anything from them. That was two months ago.

When I got the medicine bill earlier that month, it showed a new medication, so I showed the pharmacist, and he said, "Oh, that was for a urinary tract infection for your father." They had not told me that he even had one.[7] When I went out there that was the last day of the medicine, and I asked, "Would you please do a test today?" They didn't. So then I was asking again the next week to please do another test, and they told me, "We'll have that test and we will call you this afternoon with the results." Next week when I had the meeting we still hadn't heard

And the day of our meeting with the regional manager when I reported this incident, he said, "There is no reason why we have to report anything like that to you."[8] And I said, "Do you mean to tell me that if this person had had a heart attack you wouldn't tell us?" And he said, "Oh, that's different." I said, "Not to me it isn't different."

He said that they didn't have any obligation to report to a person like me unless I was a conservator or a guardian.[8] But I was the one that put them in the home. They are telling you that when you put that person in the home, you have no jurisdiction. The resident—whatever is going to happen, he is the one that says things.

In going through my files at home, here was the Residents' Bill of Rights that they had given us, I think, when my father was checked in. It always speaks of "the Resident, the Resident, the Resident." Well, needless to say, if they were able to take care of themselves they wouldn't be there!

Another thing, we understood that we should be able to request a copy of the incident report—you know, when a person falls. They told us my mother-in-law had had a fall. We had requested a copy of the incident report from the home. Then, the regional manager told me back in the letter that it was none of our business to ask for medical reports.[8] Every time they have a fall, or whatever, they're supposed to write up a report on it, when they notify the family and everything else. But the Regional Manager responded in his letter here. He says, "Related to your access to the medical records, both federal and state regulations prohibit you from seeing them unless so authorized in writing by the resident. I request that you honor this regulation and not compromise staff by requesting or attempting to see the records unless so authorized by your mother-in-law."[8] They're indicating that each resident is quite capable of handling their own affairs. Which, you know, is not true.

Another incident that I had listed to the Regional Manager when my father was so bad (he had been paralyzed on his left side for about two years, so, needless to say when he had these later strokes he couldn't move himself hardly at all), he was in bed, and I kept leaving him the tray table there so he could be lying in the bed and reach it to get a drink of water in the meantime. Every time I would go back there that table would be gone. And I kept insisting that they have it there. And finally, one of the girls told me they didn't have enough tables; they had to take the table somewhere else, and he was not able to get himself a drink of water without it.[9]

Well, we had an incident in the room the day that my mother-in-law was so bad, after she had this fall. She was very insecure about going to the bathroom, and when I got there that morning she said, "Well, I had to go by myself because I couldn't get anybody to come."[1] And I said, "Did you push the bell?" "Yes." Well, then they came in and they told her, showed her that she had to *hold* that thing down until they got there, and I said, "This can't be true." I mean, there is no way that she could do it. The bell doesn't work right. This aide said, "You've got to hold the bell down until we get there."[3]

A number of people have said to me, because I was in the nursing home a lot with my father—these patients have said to me, "I don't want to complain because I don't want to have them mad at me."[4]

BRENDA: My father's up there, he's ninety-four, at this same nursing home, #19. He'll be ninety-five in March, but he can get up, and really he waits on himself. He's not supposed to, he's supposed to have help going to the bathroom and various things. But like he says, he'll call and they never come, so he helps himself.[1] And goes when he shouldn't; he's pretty shaky. Dad would complain a lot that they had to wait till the people in the home were practically dead before they would take them to the hospital or even call the doctor.[7] And he still thinks that,

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too. They wait too long and let a person suffer before they do anything. And then about his bell, he's had more problems with the bell! First, he didn't have a light or a signal down at nursing station, but if he holds his button down that light will stay on.[5] Well, he can't remember to do that most of the time, and it takes quite a bit to push that down, so I know he had problems calling. And I think sometimes he says he has it down and they don't even know that he wants them. They just never come. At night they're a long time coming, he thinks, and I've heard that from others, too.[7]

They have such a big turnover.[2] It seems like there's always a new girl. I don't eat with Dad every week, but it seems like there's always somebody new there. And I'll tell one girl something—what I want them to do—and then the next one doesn't know anything about it, and they go right back to the same old thing. But I've felt that the girls don't have enough training how to handle people. My dad only weighs like eighty-five pounds, if he can do it himself it's OK, but they don't have time for him to sit down—he's a long time sitting down and he's a long time getting up—and so they'll get ahold of him *here*, and lift him up. Well, then, he's sore in there for a long time. And I tell them, I say, "Don't handle him like that. It hurts him."[6], because his skin, it's so thin.

When they inspect the home, do they let the nursing home know they're coming? Because it seems like they *know* here. And do they ever *work*! How do they know?[10]

CATHY, R.N.: The big problem is that the interest is not at the top coming down. Our aides are catching hell; but let me tell you they're *living* through hell, too, taking care of these people. They are not having the training period that they should be, according to the state regulations. There should be, I don't know, I think it's monthly or something like this, a training period where, for instance, we would have one on how you *move* patients—get them out of chairs, get them out of bed, and such as that. It's really *terrible* the things that I saw while my dad was there, and I observed the care of other people. He was in #19 and died a little over a year ago. But the thing is that the interest is not at the top. They're not having classes. They're not being out and seeing patients. Every patient should be seen every day by somebody who is willing to talk to them for a little while and find out how they're feeling. Now, every patient in a hospital—after all these people are not an awful lot less sick than a lot of your people in a hospital, and there they have the nurse come along and they talk to them, and the doctor comes along and they talk to them. And over there at #19, those people say, "Well, after all, we're out here, and nobody's going to bother us."[7] And that's the way it is. Now that's item number one. And, all nursing homes are not like this, but an awful *lot* of them are like this, because I have known people—after all I've been a nurse a long time, and I'm always interested in anybody that's got somebody in a nursing home, how things are going and what they do. And there are much better ones, and they're not paying more money for those better ones.

If the Director of Nurses was out there and went around those halls and saw every patient, and when a nurse or an aide is having some problems, stopped and tried to give a little bit of help and find what the difficulties are, she'd find out that it takes an hour to take care of a patient where she's got this aide taking care of six people in an hour.[1]

And that's where it's got to come from. It's got to come from the top down.[7]

One time I came in, my father had a temperature of 102 degrees. The minute I looked at him I knew that there was something wrong. I came early that morning. I didn't normally, but I was going to go away. I went in and got a thermometer and put it under his arm. It wasn't there a minute. I took it out and it was 102 degrees. I showed it to the Head Nurse as she came up the hall. She said, "Well, I wonder what happened? They said he was fine."[7] Well, I don't even think they knew whether he was breathing. The last time they touched him he wasn't cold, so they knew he was still alive. But that may have been at midnight, as far as that goes. It was after three-thirty in the afternoon before we got him into the hospital. "Well, we didn't want to call the doctor right now." I got aspirin into him right away, gave him a cool bath. I had his temperature down a good bit, but that was because *I* did it.[9] And I would not, I didn't leave, as I had planned to do. And I was not going to leave until they got him into the hospital. If I had not stayed, they would not have gotten him into the hospital. And this sort of thing, when they have no concern about patients and their complaints, that is not nursing.

ALTHEA: My father couldn't reach the bathroom by himself; he couldn't use the one in his room (his roommate was a colostomy patient), so he had to use the one down the hall. Someone would take him down there and then go, maybe on a break, or go to lunch or whatever.[6] He would *be* there for an hour or an hour and a half. I would go in there and he had been there since eight o'clock or eight-thirty. And we would report this time and time again, and it continued to happen.[7]

And about meals, the week that my dad, the last week that he was alive, he was paralyzed, and he said, "They just stuff it in, and I can't eat it that fast."[6]

HANNAH: My mother is at #19. She can't walk without help. When they get busy, they can put that light on, and if they have a bowel problem, you know, it's either *go*, or you hold, and then you're constipated. When they've got the time they are very good and pop right in when the light's on. If you watch a good aide, she will give a little time to just listen or a pat on the back, which they don't have time to do.[1] And that is something that is almost as good as a little bit of physical therapy.

CATHY, R.N.: There is something wrong at the top. The R.N.'s too often that are in charge are not paying a hoot of attention, and there's got to be some definite regulations, some definite specifications about what these people have to do.[7]

LAURA: My dad is in #19 and my husband's aunt. They are both in the same home they've been talking about all the time. They've talked about the things that we've had problems with. We didn't think water was taken enough to my father at times. And then, of course, he was left when he needed care, and he would put on his light, and he waits for long times.[6] But we can understand sometimes they're busy with other patients.[1]

MARTHA: I have been at #19 a lot. But I don't know what it would be like if I were *not* there a lot. I have my sister there,

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and she is in a geriatric chair or in bed at all times. She can't do a thing, doesn't know to put on a light. She can't communicate with them. She gets very agitated, and they speak of her being very agitated. Well, she is, and a lot of times something could be done to relieve that, I'm sure. Other times I think it's unreal. And it got real bad, and I said, "We just have to do something because she's just wearing herself out," so they agreed, and they put her on medication, and it wasn't long until there was a buildup of it, you know, in that little frail body, and it just scares me to think of these people who don't have anyone to observe them. This agitation is a big, big, problem, a little medication can be too much. And therefore I think we need *circulating* supervisors, because that charge nurse is so bogged down with her work and her care of the patients—plus all this paperwork they have to do—that they don't have time for the extra things.[7] And that paperwork just irritates me. It's taking more than fifty percent of the time of some of the girls working up there, to do their paperwork. Now, the resident is not benefiting from that one bit.

You can do anything with a pencil anyway, so why put all this paperwork on those poor girls? I go and feed every evening, just because it takes so long that I say an aide couldn't put in an hour feeding one patient.[9] My sister will shake her head with a bite in her mouth. I'm sure that they would think she didn't want any more to eat. All she wants is time to swallow.

But see, this got to me, when you were talking about the noisy patients, because if you give them enough medication to quiet them, you're going to zap them, and *what are they going to do?* They don't enjoy it, and we don't enjoy it.

ESTHER: My husband was in another nursing home, #20. And he couldn't talk, so he couldn't ask for one thing. And that is one thing, you have to *think* for your patient, and observe them and *know* when they need something. He couldn't put on a call light, and he couldn't ask them for one thing; and he was left between meals all the time without a drink of water.[3] There was one nurse who came in sometimes, only one, and she was only on part-time, that would give him a drink of water maybe at four-thirty, and they would go to supper at five. Well, there would be water on the table, but the rest of the time he was without a drink. And another thing, too, he also, they found that he had a very, very high temperature at two o'clock in the morning, and they didn't do a thing about it.[6] And they called me about eight o'clock and told me he had a temperature of 106 degrees. And they were starting to take him to the hospital then. He couldn't even *tell* them that he didn't feel well.

Somebody here said that the patients may have a hard time, but also the aides have a hard time too. I think the reason the aides have a hard time is that they have to do too much bookwork; too much writing things down, instead of just getting busy and doing the work. I think it's very important to report things so the next shift, when they come on, should read that report, so that everybody knows and follows up on things going on. This aide would get him up in the morning; she wasn't trained to know that he couldn't sit up by himself. He fell over. She pulled him up by his arm, and she said, "If you fall over again, I'm going to leave you there."[8] My husband was left tied on the toilet for two and a half hours.[6]

GINNY: So was my father in #20. My father had been on the toilet when I came, it was a Sunday or whatever it was. My friend said, "Well, I just know that your father's still in there because I haven't seen him." And she knew when they took him in there. And sure enough. Of course, he's confused and he doesn't talk much. He's just one of the silent sufferers, and they had him restrained in there a couple of hours.

My father is very confused and he doesn't call for a thing. He can't turn on his light or anything. And he doesn't get water in between either. And the doctor told me the reason his urine is so foul is because he doesn't get liquids.[3] But then why doesn't the doctor lay down the law? Lay the work on them to see that he *does* get liquids. I want them to put him to bed from one meal to the other. Then they've got a schedule that says he's to be turned ever so often, but they don't give him water that whole time.[6] And they could just raise his back, lift up and put him on his back a few minutes and give him some water, but they don't. And he doesn't get orange juice only when I'm there to see that he gets it.[7]

JEANNE: My aunt is in Nursing Home J and she has been there ten months. She was in a very severe automobile accident, and she has had excellent care. I have no complaints about it at all. I think the home is kept very clean, the meals are very good. But she doesn't get enough liquids. Whenever I feel that she needs the doctor, I call the doctor and the doctor comes to see her. I tell them at the desk that I'm going to contact the doctor, if I feel that she needs it, and they always say, "That's fine. Go ahead and do that." I am the only relative in this area. She has just done remarkably well and we really have no complaints. She is eighty-six or seven. The girls are so nice. They come in and they talk with her, visit with her. There are times, I think, when they have been a little slow in answering her bell, but she's out in a wheelchair now, and she just runs them down.

She was in the hospital fifty miles away in Intensive Care for about three weeks, and then they brought her back to a hospital near here. But you know, with the Medicare thing they only allow you to stay so long in the hospital, and I think that they send people back to the nursing home far sooner than they are able to go. So that's why they need some experienced help in nursing homes, because they have to give them total, total care.

We were talking about this paperwork, and I have noticed as I go up quite often at two o'clock or a few minutes before, that these aides who are going off the shift will be in doing their paperwork, and I *do* thnk that they tell the new aides about each patient. We play bridge with my aunt every Tuesday afternoon, and we sit over in the corner of the recreation room, and we can hear the aides saying, "Well, so-and-so about so-and-so." I *do* thnk they do that right there.

Then there is another thing. They have divided the patients. You know, it's pretty hard for a patient who is lucid to eat at a table with someone who is slobbering. And they have divided these people now, and they have what they call the recreation room and those who are able to sit and visit are in that room. And the other people are in another room, or in the main dining room.

You can give Nursing Home J an "A" as far as I'm concerned.

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RE: Nursing Home #21 NE

Number of nursing homes in this town: four

MARIAN: My Aunt Anna is a patient in #21. They called my cousin and me into the office and asked us point blank what my complaints were. And I told the director just exactly how I felt about things. But the thing is, of course, that they don't have enough help.[1] I don't know why they don't have enough help. Of course, I imagine probably a lot of it is the lack of pay. And the girls just can't keep up with it. I don't care who you are, you can't take care of fifteen and twenty patients by yourself—with two girls on a wing. Especially the ones on total care. So it was just a lack of help all the way around.

And then sometimes the food—I thought the diet was badly balanced. One day a week, I think they called it—oh, I don't know. It was a bunch of hamburger.

And another thing I couldn't understand was why there wasn't any charge nurse to supervise.[7] The desk nurse, of course, I can understand why *she* didn't. She was so busy up there at the desk she didn't have time to supervise. I'd be there in the room with my aunt, and I wouldn't see a supervisor or a nurse except at medicine time. And the rest of the time, why we just sat there and there wasn't any. They are saying that they answer the bells. Well, if they are on total care those people didn't know enough to ring a bell! And they would lay there and holler, and I would take the pans in to them.[9]

My aunt is still in that old cold room there at the end. My cousin put a note up about the way the furnace was, so it may be a little bit different now. But at the time, my gosh, I'd go in there in the mornings and Anna would be wet and cold.[6] I'd try to be there not later than around nine. Sometimes I was there at eight. One of the help said that she'd gone in there around seven o'clock, and Anna was wet and uncovered. And she was asking for a blanket. The administrator said, "Well, that isn't true, because we don't have any help that shows up that early."[8] So what are you going to do in a case like that? I know good and well that the girl wasn't lying, but you didn't dare quote her.

And many, many times, I'd hear the girls say, "Well, we have to make up these beds," and do this that and something, "We'll just have to skip the baths."[6] And they did. They just didn't have time to do it because of lack of help.[1] The charge nurse wasn't even around.[7] And, of course, I complained about *that*, and the head nurse there said, "Yes, we do. We make our rounds three times."[8] And I know better than that, because for three months I was there all day long every day. And I know that they didn't make the rounds. After I complained, why, they made a round, I think about twice and that was all. It's a miserable situation.

The administrator told my cousin that they didn't want the family there helping.[8] They told me right to my face, and my cousin was there that day. And so I went back then, and that's when I started—I'd fill in. Whenever I'd see anything that needed to be done, I'd do it, because I knew what should have been done, and I went ahead and did it there in the ward where Anna was. Alfred can tell you that I just pitched in and took care of his wife. Well, I'd be back there in my aunt's room and never see anybody. And then when I'd find out where they were they'd say, "Well, I had to go take care of . . ." (They have a long and a short hall.) They'd say, "We have to work the other side because there's only two of us on."[1] So I went back and told one of the girls, I said, "They object to the family helping here." And she said, "I'd like to see the time when my aunt was in a nursing home and I couldn't do for her!" And I said, "That's the way I feel exactly. I'm here and I'm going to stay!" And I did.

If Anna survives (which I doubt if she will, because she's in very bad shape), I'm going right back and I'm going right in there my twelve hours a day. I'm at work every day when I'm there. My cousin can't do it all. Anna can't do anything for herself—just lay there. And I gave her her whirlpool baths every day. The doctor said she was to have them because of that gangrene. And they'd say, "Well, we just don't have time."[1] So I would just go and do it.[9] Well, then I was told I wasn't supposed to do that.[8] But she went two days without a bath, so I started again. There wasn't anything else to do. The aide said they didn't have time, and they *didn't* have time.[1] I think at that time there was twenty-two to take care of. I understand that four or five have died. I know the little man died that I was good to. I felt so sorry for him. I think there was twenty-two. And lots of times there would be one and two girls on to get those patients up, feed them their breakfasts, and put them down for the afternoon crew to come on.[1]

And I filled up, and I think my cousin filled up, the water jugs any number of times.[9] That little woman that was in the bed next to Anna, she'd lay there saying, in a little tiny voice, "Water, water", and because they were on the other side working, there wouldn't be an aide in sight. I don't say the ladies were lazy; they were just overworked.[1] And it seemed like there was always applicants. I could never understand—every time you went through that front door there were people applying for a job. And they never hired them. And one time one of the girls was so disgusted—there was a Certified Aide came and applied and wanted to go to work, and the administrator told him that she didn't want him to work there because he had a job someplace else. See, he was moonlighting on the night, which everybody does now. I don't know of anybody that doesn't have to have two jobs in order to feed their family. Why, that's done all the time. And they, the girls, were so disgusted, because they needed somebody, a big, strong man to help. Why, no one, no man can feed a family on three dollars and forty-five cents an hour.

And another thing that I thought was horrible. I just nearly collapsed when I found this out! That the night aides were working in the laundry, too! That's not right! How, when you are standing back there sorting out laundry, how can you hear a patient crying for help?[5]

I didn't have any complaints about medications because we saw that Anna got hers. There were several different times when Anna's medication was stopped when it wasn't ordered to be stopped. They would say, "Oh, no, we haven't given that." And I'd say, "I know you haven't given that for two or three days, and I want to know why." And they'd look back and say, "Well, we didn't know."[7] So they would start again. We reported that to the doctor. He had a fit. My heavens, you're jeopardizing the patient's health![3]

When they called us into the office, they just denied everything I said, and said it wasn't right. And that there was going to be a change. And there wasn't a change all the time I was there. And they said that I didn't know this, and I didn't know that.[8]

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And so then I told them about the mess when they moved my aunt; they moved four patients in one day and threw all the stuff in the room. And there I was with Anna and the other three patients. Clothes piled up on the beds and everything else. So I opened the closet to put away the clothes. Cockroaches and dirt! It hadn't even been cleaned out. And so then Bee's daughter came in and she was horrified. She said, "Why, these clothes here on the bed are not even Mother's." And so she got busy and she picked up a sack in that closet and brought it over to me, and in that sack were five dead cockroaches and a bunch that had been used and a comb that was used.[7] And I said, "That's not the half of it. In the drawer over there where Catherine's stuff is supposed to be, there was packages marked 1982 that had never been opened." They were gifts. Now, I saw that with my own eyes, and I told the administrator that day. I said, "Why did you move four patients at one time into the same room? That's not good organization at all." She didn't like that at all. So I told her, I said, "When I close these draperies (my cousin was there that day), I took the drapes and swung them shut, you know, to screen off a patient. The dust and dirt just flew. I nearly coughed my head off." I said, "My gosh, there's a year's accumulation of dust on these draperies." So I asked the aide, and she said, "Oh, yes, they haven't used this for over a year and a half. It's been used as a storeroom." And she moved four patients into that room that day, because I was there and saw the whole procedure and stood around with my mouth open.[7]

There was one little man I really felt sorry for. He was deaf, and he would just have the awfullest time getting to the bathroom. He was just always wet and dirty[6] and he'd try to go to the bathroom or get to the table, and he would be flooded before the poor little thing could get halfway down the hall. So then I just got so I would go over there and touch him on the shoulder and point to his wheelchair, and I'd take him up there and put him in his place. And when I didn't have time (I was doing something else), I would ask the other volunteer, "See that Dick gets here." But they were just busy. They had to ignore him because they were dishing out the food.[1] How can you bring patients to the table when you're in there handing out the iced tea? Then I would sit down at the table and feed two different ones. There was one big heavy-set woman who was very, very paralyzed, and she was a real problem to feed. And then the other blind man. I think he was the oldest one there. I fed him. If I had to boil it down to two statements I would say: they need more help (they need to *hire* more help)[1], and they need to get off their fannies in that office and work on that floor and see that the work is done.[7]

RE: Nursing Home #21 NE

Number of nursing homes in this town: four

MARSHA: My Aunt Anna is a patient in #21. I see so many deficiencies there, nothing would surprise me. The uncleanliness and the care of the other patients. The patients are left wet or dirty so often.[6] And as many restraints as there are, and the lack of exercising the patients. The lack of quality meals. The lack of health care. Finding my aunt wet and dirty is one reason we're there so much. My cousin has gone in in the morning and every time she would find Aunt Anna in the mess that had happened during the night. No one had bothered to clean it up.[6] If we complain to the administrator, we get three answers: "We're looking into it" or "We will look into it", and "I've been informed."[8] But nothing changes. We've never heard of the girls getting into trouble over patient care.

There's not enough aides to take care of those people.[1] And they were talking last week of laying some off again because they didn't need that many, the administrator said. They were going to send the one girl home at nine o'clock. She came in on the three o'clock shift. They were going to send her home at nine just out of the clear blue sky. And these are all heavy care patients on this side. The girls just blew their tops and said, "Who's going to take care of these people? There's no way in the world one person can even handle them, much less take care of them." The administrator finally just said, "Well, OK, stay tonight and we'll talk about it tomorrow." Well, if she ever did, I haven't heard if she's even done anything.

Meals are sometimes very short. And they do not know how to puree food. Or else the stuff is so tough to begin with it's impossible. Anna's food has to be pureed, and many times it comes down and it is *not* pureed.[7] Then in case it's something that she cannot eat, I will go and ask for cottage cheese or something like that, which I do not agree wholeheartedly about, but which I do anyway. And we have a whole box load of baby food that we supplement Anna's meals with,[9] when we see what she has and what she can't eat. Her dentures are loose and she can no longer chew. I think she's afraid of choking. She wants it out of her mouth. Some of it you can just mash and mash and mash with your fork trying to get it whipped up a little more, and you just might as well forget it. And I used to take the food back and say, "This has to be pureed." Half the time they'd say, "We have the pureeing machine washed." And I didn't say, "That's your problem." But that's what I felt like saying. Didn't want to mess it up again, I guess. I'd just wait there while they got it done. I thought, "If they have to wash it twice that's their problem. They aren't carrying out orders. That's not my problem."

Now water, that's a really pitiful thing. The pitchers will be empty and one day my cousin said that they were gone when she got there. She says that she got there one morning, it was between ten-thirty and eleven. And that day there was not a pitcher brought down to any of the patients (my aunt's in a four-bed ward now), nobody had any water all that day. And the next day there was no water for them.[3] My cousin went down and got her own water. I've filled the pitchers up many times.[9]

To me, the head nurse is the biggest flop of a RN. I thought that I had seen a lot of RN's in my time, but she is one of the least knowledgable or the most unprofessional in caring about people that I think I've ever seen.

Another thing that I do object to is their bathing people and not drying their hair, letting them run around with wet hair in this kind of weather.[3] We bought a blow dryer for Aunt Anna. There were two donated down there and they seemed to be where nobody could find them. We've seen people out there with their hair dripping, and some of them have long hair. And one time we couldn't find blankets. And my cousin was just aggravated. She went over and bought two, and also bought two bedspreads, because my aunt had been without a bedspread for a week.[5] And then the blankets disappeared while she was gone, and we like to

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9. Staff tasks performed by visitors
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The Kansas Department of Health and Environment is responsible for nursing home regulation.

never got those blankets back. And they don't wash the patients' hands. Those patients will wheel those wheelchairs through, you know, whatever, and go down to eat and then there's nothing there for them to clean their hands after the, get there.[9] And there's all kinds of contact they make on their hands. I'm surprised they're as well as they are. I don't think they even wet the washcloth for my aunt to wash her hands or try to wash her hands if we don't happen to feed her and she has to feed herself.

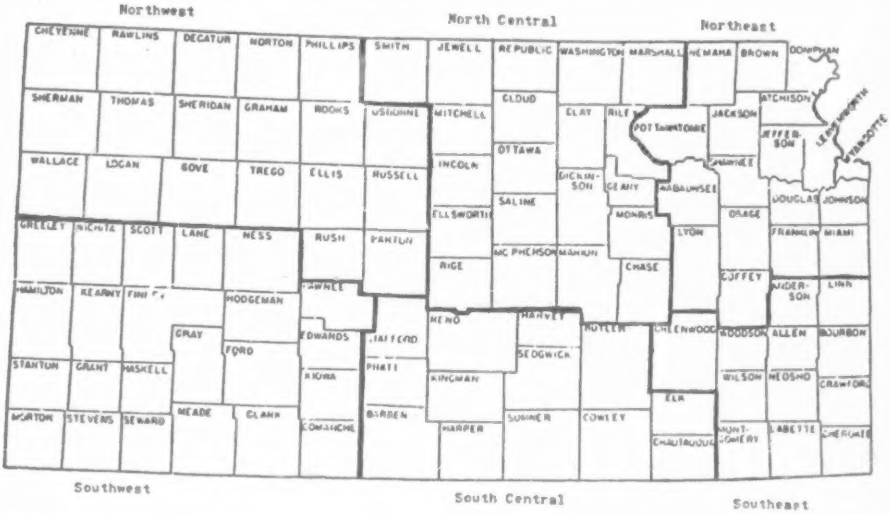
I called the main offices of the chain that owns the home my aunt is in and I got them. I told them there was a lot of camouflage, a lot of things done to dress it up, but not a thing done for the patients. And they just think our whole problem is that my cousin and I are there too much.[9] And I said, "It's just a fact that we see more that goes on than a lot of people do." And I said, "Things that not only concern our aunt, but concern other people."

The nurses are thrilled to death to have us there, because we can feed and turn Aunt Anna and do things, and we can clean up her bed and et cetera.[9] Otherwise, why it isn't done, many times. There are some good help and there are some very, very poor help. Then, my cousin—she just said, "I'll volunteer." She went in and worked with all of them. They said, "Oh, my, she did such a nice job with all the patients."

Being there so much, we see the way people are fed. The incompetence of some of the help. And since my cousin has some training and works out of the clinic there, doing nothing but taking care of geriatric patients at home and goes to the hospital with them when they have to go to the hospital, that she kind of knows what is right and what's wrong. And she said she has seen dog kennels run better than this outfit here. It just really is disgusting.

Regional Administrative Districts for the Department of Health and Environment

(These divisions are the ones we have used for locating nursing homes in this Special Series of the KINH newsletter.)


Northwest
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CHEYENNE
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DONIPHAN
SHERMAN
THOMAS
SHERIDAN
GRAHAM
ROOKS
OSBORNE
MITCHELL
CLOUD
CLAY
RILEY
POTTAWATOMIE
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LEAVENWORTH
WYANDOTTE
WALLACE
LOGAN
GOVE
TREGO
ELLIS
RUSSELL
LINCOLN
OTTAWA
DICKINSON
GEARY
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ELLSWORTH
MORRIS
OSAGE
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WICHITA
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RUSH
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LYON
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MIAMI
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MARION
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CHASE
COFFEY
ANDERSON
LINN
HAMILTON
KEARNY
FINNEY
HODGEMAN
PAWNEE
RENO
HARVEY
BUTLER
GREENWOOD
WOODSON
ALLEN
BOURBON
GRAY
EDWARDS
STAFFORD
SEDGWICK
FORD
STANTON
GRANT
HASKELL
KIOWA
PRATT
KINGMAN
WILSON
NEOSHO
CRAWFORD
ELK
MORTON
STEVENS
SEWARD
MEADE
CLARK
COMANCHE
BARBER
HARPER
SUMNER
COWLEY
CHAUTAUQUA
MONTGOMERY
LABETTE
CHEROKEE
Southwest
South Central
Southeast

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KINH News

KANSANS FOR IMPROVEMENT OF NURSING HOMES, INC.
913 Tennessee, No. 2 • Lawrence, Kansas 66044 • (913) 842-3088

SPECIAL SERIES

Vol. 1, No. 5 December 1985

INSIDE KANSAS NURSING HOMES

RE: Nursing Home #22 NE

Number of nursing homes in this town: five

Celia did not know who regulates Kansas nursing homes.

CELIA: My aunt has been in #22 for two years. She had fallen at home. We presumed a bone broke and caused her to fall on the floor. So, the hip operation was successful and she was in the hospital for two months, when they commence to push them out of the hospital. Then she went to #22 in an ambulance. While she was in #22 she was hospitalized; she had dehydration, a bowel impaction and a bladder infection. I don't think that she had the best care. Now they were kindly to her, but all three of those things I have mentioned were something they should have known about all the time that she was there. And it didn't happen overnight, of course.

She had water, but it was on her bedside table, and it was pushed back into the corner.[7] She finally got so she wasn't even able to reach it or to open the drawers. I noticed that as long as Medicare was helping her, she got therapy and some walking, but when she went off Medicare, and was paying her own bills, no more therapy. It is frustrating or something. It seems as though that all those people that are paying their own way weren't getting therapy, but the ones on welfare or Medicare were getting it. She walked a little bit as long as Medicare was paying. After that they didn't give her the opportunity. And she would sit up in her chair to eat her meals. But I think there was neglect there in that area, dreadful. The aides don't have enough time[1] and it is such a fast changeover.[2] There were very few that were there any time at all. And, of course, some of them were older and retired and out of business all together. But some of them were young girls and they were just not interested. Some of them were very good, very kind, but they had no time.[1] For instance, I needed a nurse real bad one day when I was there. My mother had had an accident. She had gotten her hands into it trying to take care of it herself and a girl looked in the door and she said, "I don't even belong down here." So away she went and I tended to it myself. That happened quite a few times.[9]

At one time she was able to go to the dining room in her chair. I stopped there at suppertime one evening and I saw her hands and it was dreadful. Dried BM on her hands. They had not been washed.[6] It was dreadful for her, it was dreadful for the other people at the table. And another thing, there was no toilet tissue on her table or on her bed or anyplace. I was in her bathroom and I think there was tissue in there. But of course she couldn't get it. She could not reach any near her bed. She tried to use Kleenex or just whatever she could find. Most of the time, there was Kleenex.

You don't see many nurses until there is something really critical happening. They are there at the desk but with paperwork, I guess. I'm sure the paperwork just overflows.

One time, there was a lady came there early in my aunt's stay at the home and she asked me if we had any complaints or if we needed anything or saw anything wrong and at that time we hadn't. Because she hadn't even been there a month. After that I never saw anyone inspecting.

About the bladder infection, of course, she wasn't drinking enough water for one thing. And, of course, she

About "Inside Kansas Nursing Homes"

This is the fifth Special Series KINH Newsletter which contains our report on the quality of nursing home care in Kansas as seen through the eyes of relatives and friends of nursing home patients. Frequent visitors to nursing homes are best able to observe actual day to day care; their comments are therefore deserving of our close attention.

We began our conversations with them in June, 1984. All comments presented in this Special Series have been taped and transcribed since that date. We talked with some individuals privately; we also held group meetings in several Kansas communities. We have edited the comments to omit mention of non-recent events or of any references which might pin-point speakers or patients. All names of speakers, patients, and staff members have been changed.

Nursing homes discussed are identified by a number, arbitrarily assigned, and by geographical region: NW, NC, NE, SE, SC, and SW. For example: #3 NW. Nursing homes mentioned only in passing are assigned alphabetical letters. For example: Nursing Home A.

These conversations with relatives and friends of patients will be continued until we have received comments on at least forty to fifty percent of the total number of homes in the state (370).

Volume 1, of which this issue is Number 5, covers about 43 nursing homes.

Petey Cerf, Editor

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wasn't always kept clean.[6] I usually went on an afternoon, but my brother went a lot of times in the morning. Probably 9 or 10 o'clock. I was told by the lady at #22 that Kansas has no jurisdiction over #22 in what their procedures are or what they charge. I can't think they should have been allowed to come into Kansas if we don't have any control over them. This lady told me that they had a right to raise the rates every quarter, I believe it is.

I noticed when my aunt wasn't kept clean and often I would get a washcloth and take it to her myself.[9] She could wash her face and hands and if they would have put her in her chair and taken her over to the lavatory she could have washed her own face and hands. They didn't do it.[6] But there was a lavatory in her room. Hot and cold water and there were paper towels there. There was a toilet between the two rooms that either side of the room could use. But, of course, she was never able to do that alone. If she rang for an aide at night, like they both said, "We never know when they are coming. Wait, wait, wait." And they would get bedpans and they would turn on their light when they were through, and they would sit there until there was red rings on their bottoms. Sometimes my mother was able to take it out from under herself and then those were the times her hands got in trouble. I never went to visit her for less than an hour and I know that sometimes she was on it all the time.[6] I wish there was some other way for people to be taken care of.

They never measured the urine and they never seemed to pay any attention to it. They just emptied the pan and that was it. And it was always an aide. It was never a nurse that even saw what was happening.[7]

And when they took her to the hospital she responded to the treatment wonderfully. It wasn't like her mind was not clear, it was as clear as a bell, up to a few minutes before she died even. They called it pulmonary something. You can't even read what is on the chart. And I've been going to get someone that I thought could read that. She had wasted away so that you wouldn't believe. She couldn't eat. She couldn't swallow enough. And she didn't want the lifesaving thing used. Like my brother said, in his own words, he still thinks nursing homes "is a ripoff."

Lucille did not know who regulates Kansas nursing homes.

LUCILLE: My father is in #22. He's been there about three weeks. Three and a half years ago he had a stroke, and he is paralyzed completely on the right side; and, of course, when you have a stroke on the right side it affects your speech. He can't talk. I took care of him for three and a half years at home. I said I was not ever going to put him in a nursing home, but the last he was in the hospital, the doctor said he was going to have to have I.V.s, and they couldn't find a vein, so they had to put a thing in the shoulder that's under the skin. So, the doctor said, for the time being, put him in a nursing home. And if he gets any better at all I'm going to bring him home.

I'm not happy about the care. He had a BM, and I told three different nurses, and the response was: "Well, I'll get someone to help you. I'll get someone to help you." And I cleaned him up the best I could, you know, I mean, got him out of it and got *him* cleaned, but before anyone ever came, I had to ask three different ones to help me. I'd already done most of it.[9]

They are supposed to push fluids on my father, so they can get him away from this I.V., but yesterday there wasn't a glass in the room.[6] There was no straw, nothing, that he could have even a drink of water.[3] I have never yet seen them to offer him a drink. There was a pitcher, but the water had been in it for a couple to three days. He was in a private room until yesterday, and yesterday morning about nine-thirty they moved a guy in, in the same room. And I didn't see them do *one* thing to him.[6] They put him in at nine-thirty, as far as I know he probably didn't even have any lunch because he didn't have a table. And of course, he didn't get any water. Nothing! And my father, I'm after them all the time, otherwise I wouldn't get *anything*.

I took a little trip this last weekend, but I didn't feel comfortable in leaving my father unless I had some extra help. So I got a girl that had helped me out at the hospital, when I was up at the hospital. Since he can't *talk*, you know. But anyway, I didn't feel comfortable leaving him to the nurses' care. The girl goes and stays when I can't go, you know. But they should be able to take care of them without you having to hire extra help!

Now, if I hadn't been there that time my father would have lain in that BM for I don't know how long. And he's got one of the worst cases of rash. He never had a pressure sore or a rash or *anything* all the time I took care of him at home. They never use any lotion.[7] This I know. And he had been there for, oh, I don't know how many days, and I know his feet had never been washed.[6]

Wilma did not know who regulates Kansas nursing homes.

WILMA: My sister, Virginia, has been at #22 for three years. There are not enough aides.[1] I go out to see Virginia usually between 10:30 and 12:00 in the morning and the beds sometimes are not made. And ironically, it seems always to be Sunday. There seems to be a big turnover, new faces all the time.[2] I do know, however, that they change the help from one wing to the other because they don't want them to get too fond of some of the patients or they don't want them to get too well acquainted with them. I think they do a lot of rotating, at least every week. Maybe even more often. It hardly gives them a chance to—well, they don't know anything about the patients really. My goodness, thinking back, Virginia has been out there at #22 for two years and a half and there probably aren't over six people that I can truly say I know. That is how fast they have them. Come and gone.[2]

When she went in, she was very bad, just recovering from a stroke and was bedfast and partially paralyzed. And was able to feed herself with her left hand but she is a right-handed person. So, all this had to be learned. She made a marvelous recovery. She had therapy, of course, up until, well, whatever length of therapy is allowed through Medicare. They say after so many treatments that if the therapist can't say, "I see improvement and there is reason I need to continue this," then, they are not allowed to give any more treatments, unless we want to pay for them. There are some of the girls there at the home that do walk the patients but, I tell you what, they are short of time due to the lack of help that makes them short of time, so they don't get around to do these things.[1] The amount of money that we pay, I think those services should be available for the patients. Virginia has water on her little stand. She can

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get a drink by herself. She is also where she has a sink and she can draw her own water. She walks with the help of her walker.

The biggest problem is the cleanliness of the beds, I think. I can see where it would be, though. For instance, Virginia has a urinary problem, has had for years. And her wheelchair pad might be wet and also her bed.[6] And this is the sort of thing—I have gone out and sat down on a made bed and when I got up my rear was damp. So then, I have reported that because that meant there was wet bedding under that that had not been removed. Now that, to me, is one of the worst things that has happened. And one day I did go out and the bedpan was sitting beside the bed.[6] and this was eleven o'clock in the morning. It was time for her to go to her lunch and there sat the unmade bed and the bedpan. Well, of course, I almost died. And, of course, the bedpan is not covered. That time I complained to the lady that was in charge of the wing that day. She was embarassed. Well, you see once in a while they have an emergency and one patient has to have a lot of attention; and when they are short-handed, maybe the three of them are working on that particular patient. It takes them away from all these others.[1]

And Virginia has a problem, she likes to get up real early and she asks the nurse to come and get her up. They will say, "I've got a bunch of people to get up here this morning. Now you just be patient. You just lay there and be still. I'll get to you when I can. You just don't realize how much work we have to do out here." I can't imagine anybody being that eager to get up, but she wants *up*. She has laid there long enough.

For awhile she didn't get enough baths, but it seems like things are looking up in that respect. For one thing, she has a problem that requires a whirlpool bath, and this is because she has sores on her ankles. The baths are marvelous. She gets those two or three times a week. Like I said, at the moment things are mediocre, but better. I have seen them a lot worse than they are at this very moment.

RE: Nursing Home # 23 NE

Number of Nursing Homes in this town: four

MARGERY: My husband Vernon, a veteran, was sent from the V.A. Hospital to # 23 in the middle of September. Just three weeks after he had the stroke. He needed care. I mean he wasn't able to do anything, to handle hisself in any way. When he first had this stroke he had a sleeping spell for about two weeks, but he had come out of that and he just needed a lot of care getting him up and down, things like that. He still can't walk by hisself. That's the thing that has burnt me up. When we took him to the hospital instead of them getting out and working on him, and keeping his leg and his arm and one thing and another exercised, they just left him lay.[6] And the doctor had left orders for him to be got up in his chair three times a day for at least an hour. Well, they got him up for the three hours all right, but they would wait until evening and get him up and then make him sit there for three hours. He was there for about three weeks. Then they referred him to rehab and the rehab doctor there refused him and wouldn't have him. And then they farmed him out in the nursing home.

Why the rehab doctor refused him, that is an answer we never really got.

He had two or three choices of homes that we could put him in but this was the only one that we could get him into. They had one home, Nursing Home K, but that thing stunk so you couldn't hardly walk down the hall. And that was no place for him. You could see there wouldn't be no care there. Even the environment in it wasn't good. All you had to do was walk through the door and that told you you didn't want nothing to do with that. They had Nursing Home L, it looked like a real nice place, nice and clean. But we couldn't get in there because everybody else wanted in there too, you know. They was supposed to get us an opening there, but we never did get one.

So we put him down there in # 23 and they put him in a room with a man that was very, very ill. He was a nice old man, but he just screamed and hollered and carried on all the time. And I wanted them to put him with another veteran that was in about the same condition Vernon was—somebody he could communicate with. He had his mind and he could talk. He could visit, but he couldn't visit with a man like they had in there. Well, they couldn't put them together because of the skill factors—or the skill levels, they said. The other man was in the same position Vernon was in only his stroke was on the other side. He was a veteran. They farmed him out there too, you see. Then when that first roommate passed on, why they put another man in there. Of course, he passed on too. Nobody to communicate with. When Vernon went to the dining room to eat, he had to eat with people that mentally was disturbed and he was just getting in the same groove they were in. They set a pitcher of water on his bedside table and he couldn't get to it, because it was on the wrong side of him—the paralyzed side.[7] He had a call bell but it was hard to get them to answer, you know. Sometimes he would wait for hours and hours and hours.[6]

He got three baths in the three months he had been there, and one of them, I had told them they better give him a bath because I was going to take him out for the weekend so they finally gave him a bath.[9] And then one of the nurses come down and wanted to know why he said he had only had three baths.[8] And he said, "I've got my mind. I'm not crazy." They do all pencil work, that's what they do, the nurses.[7] So we took him home and cleaned him up. I doubt if there were enough aides at #23—not enough to take care of them because sometimes there wouldn't be but one or two on a floor.

They put these bloomin' diapers on him, you know. If he had an accident during the night, well, he wore it till the next day.[6] Well, #23 smells that way.[5] It is just gettin' where it smells that way, it really did. They got to where some of them aisles down there were pretty graunchy. But this one nurse told me they weren't about to lift him on the lift and set him in on the stool, which they could have done. She just wasn't going to put herself out that much.[7] I think she must have been an aide. She just told it in that many words. I don't know what her name was but that is what she told me.[8] All they had to done was got him up, lifted him up and set him in there, you know, so he could have went naturally.

At that time, I didn't have the equipment here at home to do it with. We went and got a lift when we took him home and we put him on the stool. We had aides that came out. County aides I guess they were, come out and check his blood pressure and his sugar. And then one nurse come once a week and give him a bath, maybe twice a week. No,

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she just come once a week, I believe it was. We exercised him. That's another thing. They didn't give him therapy down at the nursing home on his left side where he is paralyzed. They give it on his right side.[7] I asked the lady one day, I said, "Well, why don't you put in the time that he is in here exercising his leg on his left side and let him take some of his time and exercise his right leg and arm." And well, she says, "That's not what I'm being paid for."[8] I tell you, I got so mad I just croaked. She meant she wasn't going to do it. I mean it was easier to do it on his right side. While he was exercising his right leg and his right arm, she was running four or five others through at the same time. Instead of her spending the full time that she was allotted to take care of him, as I say, she was taking care of four or five others at the same time. If he had been doing his left side like he should have been done, why, she would have had to spend some time with him. I could see that, and she was being paid for so many patients.[7]

We had visiting nurses when we first brought him back here. When we took him out of the nursing home to begin with, I took him to his brother's and I kept him up there for a month or so. Then I brought him on down here and then the county sent out nurses. And they done that until June, somewhere along in there. Anyhow, Medicare wasn't going to pay for it any longer. Because of the time limit, it was up, was why they didn't do that. One of the nurses that came out here tried to get the VA to help him on certain things, you know. And the remark that she got from them up there was that all they cared about was getting him set up in a wheelchair. They wasn't interested in anything beyond.[8] There wasn't enough care and too much pencil work on what they are doing. Of course, they are going to deny that pencil work part. They know they have got to do that pencil work. The social worker, I complained to her, see, at the VA hospital. And she went out there to #23 and said everything was in order, their records were up and everything else. She thought everything was just working nice.

In the first place, I don't know why the VA have to farm their veterans out, why they don't stay there and take care of them. It don't take a bit more help to take care of them in a Veterans' home than it does to take care of them in a nursing home. We spend a lot of money overseas and give a lot of money away. Let's build some more homes for Veterans. If we can't take care of our own people here, there is something wrong, you know that. I think we need to do a lot more at home than we are doing.

RE: Nursing Home #24 NE

Number of nursing homes in this town: three

JEANNE: This lady, Margot Browne, a member of our church, was in #24. We called on her a lot. The pastor did and I did and a couple of other ladies did. And so I was there a lot these last three years. And it is the worst it has ever been over the years we have called on them.[6]

We have a calling group out of our church that visits regularly. Right up at the top of the list visually, as well as apparently care, is Nursing Home M, and Nursing Home N doesn't seem bad. We have never had anyone there on too long a term basis. We have had people there short term from having a stroke and being there before they go home or somewhere else. We had a man there from our church who had cancer and he was there until he died and that was pretty short term. I think Nursing Home L is good. Betsy's mother is there at Nursing Home L. I think she is happy with the situation there. She did have an incident at Nursing Home L where she feels like her mother was left in the wheelchair too long and maybe just because the aide was upset with her mother. But I think by and large, that is an individual thing with one aide. I think by and large the care there seems to be very adequate and it is always clean. Anyplace else I go in, everyplace else is clean except #24. I have a really sensitive nose and I do have allergies, and the smell hits me like that. #24 is the only place I go in and say, "Oh, yuck."

I see a lot of people around there. What I don't see is a lot of good planning about how they are going to use their time and energy. I see so many people sitting around in that circle. Most of them probably are aides. I just have a feeling that if somebody had those people really organized and gave them a sense of direction and said, "These are your jobs and now do them. Let's work on this together," and go in there and teach them how to scrub something.[7] There is no excuse, absolutely no excuse for Margot's bathroom.[6] It smelled like spilled urine every time I went to call. And nobody was ever in that bathroom except us, and her aides. Margot was totally bedfast, so was the lady next to her. The only thing that could have been spilled was the urinals by the aides. There is no excuse for that. I went and asked them to clean it up one time. I said to them, "I'm nauseous. I can't stand the bathroom."

Margot was a lovely lady and was a professional lady in New York. After she retired from that, she was an LPN. She was a lovely, gracious lady and some of the aides would come bouncing in and say, "What can I do for you, Margot?" And she would seem to have a really good rapport with them and I think they cared about her very much. It must have been the housekeeping staff then that was so far understaffed, I guess, about the smelly bathroom. And there was urine laying under the lady's bed in her room. The urinal had been kicked over. It was under her bed the whole time I was in there and I just couldn't stand it anymore. I saw one of the aides going by and I called to them and I said, "Could you please come clean this up. It smells terrible in here." And she said, "Sure." And she was agreeable, you know. But no one came while we were there. Maybe it is the housekeeping staff that is their problem, or maybe management of the housekeeping staff.

I told Bob one time, our pastor, I said, "I wish they would give me two months out there. Let me rip up the carpet first." The carpet is all over the hall and the lounge, and it is full of urine. It's horrible. There is no way they can keep it clean. They should rip that up and tile the floors. Every other home I go in there is somebody behind a polishing machine and there is somebody with a sign up, "Caution, wet floor," in every other home. At #24 there is sometimes a sign sitting in the elevator, but the elevator reeks and looks like the floor has never been scrubbed. The sign says, "Caution, wet floor," you know one of those. Sometimes it sits right outside the door or in the elevator. I suppose, obviously when they make some sort of spill in the elevator, I suppose they make some swipe at cleaning it. But I mean it is not clean, it looks like it has never been scrubbed.

I talked with a lady whom I assumed to be in charge. She is nice. She says, "We know we need to get a new source for our cleaning supplies. We have noticed that this

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cleaner we are using now is not working on the asphalt floor and it makes the floor sticky." Because this is what I complained about, and we tried to do this in a diplomatic way. We did not want to cause trouble for Margot, but Bob felt with talking with her that maybe they did make it rougher on her when her son came to visit. Her son hardly ever appeared and when he did, he was usually very upset. He had a bad situation at home and didn't come very often, and then he was upset with his mother's care. I did try my very best to be as diplomatic as possible. I said, "There is something spilled on Mrs. Browne's floor. The floor is sticky." Of course, you just got this feeling you were walking on "yuck".

There is carpeting just in this front hall, and the main floor lobby, which is where the people sit in wheelchairs with colostomies and incontinent and so on. Some of them have leakage problems and so forth. There is carpet when you walk in and it hits you in the face because that is where the carpet is. That is when I walk in, there are two doors to go in, there is a door and a little entrance type of thing. I don't even know why it is there except to keep the cold out in the winter time. It is just the width of the door and you open the first door and wham, it hits you. There used to be wheelchairs that set out there and I think the pads on the wheelchairs were dirty. It does have a tile floor, although it may have never been cleaned, that grout gets dirty. That grout contains the smell. That is where it hit me in the face. I finally complained about that, and that is when the lady told me, "Well, they were cooking cabbage and it probably was cabbage that I smelled."[8]

This lady is in the back office. She used to be at the front desk but I think they promoted her, quote unquote. She is not at the desk there where the visitors were asked to stop. Now she is in back, I used to know her name, she is nice, smiles a lot, but I don't see any action being taken.

Margot laid on a wet pad much too much. She many times complained about that or sometimes she was dirty when I would go in. Just laying in her own dirt.[6] That just turned my stomach. I couldn't stand it. I did mention that a few times. I said, "Please let someone go in and change Mrs. Browne. She is soiled."

RE: Nursing Homes #25, #26, #27, #28, #29 and #30 SE in three neighboring towns.

Number of nursing homes in these towns:
A'ville has three, B'ville has one and C'ville has two.

NANCY: My husband, Philip, was in #25 in A'ville for a year and, as I told them and as I told the manager, there was no way that they could take care of him the way I'd like it done. So I asked permission to go to them and talk to them about anything I found wrong. I asked them please not to get angry with me, because I would be very apt to be angry when I talked to them. And just to please put up with it, and I'd try to work with them. So we did. Things were fine at #25 for close to a year. And in the meanwhile, I had had surgery and was gone from town for three months. And when I came out the doctor said, after I was home for a month, "Just get away from here, out of town for a week and rest, because it's getting to you." There's no way they could understand that it would get to me if I *couldn't* go. You know, you have to go. There's nothing that makes you. I would think, "I won't go," but then I had to go, because I wanted to know how he was today. And I got so I knew other people there, and I wanted to know they were alright. Because they had to wait for somebody to come and do something for them.[9] And lots of times I could do it, and I wanted to do it.

I came back from my rest trip unexpectedly, in five days instead of seven. They had changed supervisors at #25, and things were different. I could not find my husband, Philip! I asked where he was from three different aides, and nobody knew. They were very busy; very, very busy. This was eleven thirty in the morning. So I asked the nurse, and she said, "He's sitting *there*." And I had passed him twice and I didn't recognize him! He was leaning over with his head almost to the floor, because he was a very tall man. His face was dirty; his clothes looked like they had come out of a rag bag. I found that he was running a temperature. When I went to pull him up he almost screamed, he was so sore under here from leaning over that chair arm, which was metal.[6]

So, that's when I called you and everybody else I knew and wrote letters to every Representative that we have in the State Legislature, and in Washington. I wrote to all of our Representatives and all of our Congressmen. I wrote to Nancy Kassebaum and to Senator Dole. I wrote to Harder. I wrote to anybody that had anything to do with it. I wrote about forty letters. I wasn't complaining. I stated the facts, just as I'm telling you, because they haven't changed. I mean, these facts have not changed at #25. Everybody else looked the same way. I called the people that supposedly owned it, and found that I was talking to the secretary in another state.

VOICE 1: This was two years ago.

VOICE 2: It changed twice since then.

VOICE 3: And the man who was running it at that time is now gone. There's a new administrator now. He came about ten days ago.

NANCY: So I wrote these forty letters about #25. Well, of course, I had a response from everybody that they would help. Our Kansas Legislature Representative was a great help to me. He gave me all the addresses. He gave me advice. I had written a letter and I said, "May I copy this?" And he said, "No, write each letter by hand and sign it. The only thing I can find wrong with this letter is, you must say at the top, 'My husband is in a nursing home.' Don't be so impartial, because they must know that you are truly interested." So that's what I did.

Well, then, the administrator, Ned Brown, said, "We're doing the best we can with him." I said, "Then God help the rest of them." Because I found out he was running a temperature and stiill sitting up. Well, of course, they immediately had three girls back there. So, somebody else suffered, because they never had an extra.[1] They had the minimum! But if somebody's sick, who's to know if the minimum's there? I mean, the minimum amount of help required daily.

PRISCILLA, R.N.: They can't get somebody right offhand, if an aide doesn't show. They might try, but they never have that many on call.

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NANCY: So that half of the time they were short of help.[1]

RACHEL: And that's more money for them! That is not fair to the patient. And that is not fair to the aides. My mother is at #25.

NANCY: Those aides, really, most of them, I had no fault to find with them. They really tried; and I really was very fond of most of them. I went in always in the morning. They knew I would be there in the morning. And I was there around nine. Many times during the week I was there in the afternoon or the evening, one or the other every day. So they never knew when I was coming. Philip had always been taken care of, as had your mother and the little lady next to her. They were always pretty well taken care of. Now Sara—

VOICE: She was the grandmother of a nurse who was on duty there.

NANCY: And as long as that nurse was there she was taken care of. But Sara was hard to take care of. I would go by and she would be dirty and she would want to be cleaned. And she'd be yelling. Well, it just got to be a habit. So they never knew whether she needed care or not.

PRISCILLA: Well, damn it, you find out if she needs care! You don't *guess* she doesn't and stay away.

NANCY: I had been gone five days. The supervisor at that time said, "I'll take care of him." They weren't even doing his laundry, because I did it. He broke out, and so I did his laundry. But when I came back and I found this Ned Brown there, *things had changed*. And I told them when I talked to that secretary out-of-state, I said, "There is no way anybody can run a place efficiently when they don't have a plant that is running." The washing machine was not working half of the time. When it did the water was too hot. The dryer would break down. They wouldn't have enough sheets! I said, "You don't have enough sheets. You don't have enough towels. You don't have enough spreads." They don't have enough of *anything*.[5]

RACHEL: When it was in litigation there over the salaries that were unpaid, all of the personnel—everyone—lost two weeks' pay, in the spring, when the ownership changed. Because the new people wouldn't take responsibility for the salaries of the people they bought from. And the people they bought from just bowed out. So everybody, including the people on minimum wage, everybody lost two weeks' pay. And the attorney that they hired couldn't find out who was responsible. They never were able to determine who had bought it or who had sold it either, I think.

SHIRLEY: My mother went into #25 in September of 1982. Ned Brown was there. I think it was the following February or March when it was in litigation. And I know one couple, both husband and wife were working, and they lost a couple of weeks' pay each. And they had children.

NANCY: Philip was at #26, also in A'ville, for two years, until he died, after I took him out of #25. And truly I had only two complaints to make and I made them to Don. And he said, "I'll take care of it," and he did. Don Evans is the manager.

I was pleased with the way they treated my husband at #26. I was not at first. He did not like anybody then. They were all strange. He did not like to have them all handle him, even with me there, because I was helping with his bath and everything.[9] And they were very patient, and talked to him kindly. He had had several strokes and he had three broken vertebrae. It was impossible to take care of him at home.

Nursing home #26 is a hundred percent better than #25. I told them the other day, "If I need to go to a nursing home and you have no room," (Because they never do. They're always full.) "Put me in the home anyway. I don't want to go anyplace else. Just put me in the hall!" And I mean that. And I was there enough to know that they at least give it a stab at trying.

RACHEL: What about response to the patients' lights?

NANCY: Well, it was fair. I won't say excellent.

RACHEL: The reason I ask is because a neighbor of my mother's had to go to #26 for convalescence. She's not there now. And we, of course, worry about the things that aren't getting done at #25. We need a private nurse, really; Mother needs a private nurse, and we can't afford it. But we worry about the things that we don't get done. And I had talked with my neighbor about #26, and she said, "I had good care," but, she said, "Rachel, *I'm* able to go to the bathroom on my own. The patients who were in wheelchairs and tied to wheelchairs were taken every two hours. They don't take them when they want to go. They take them every two hours."[6] She meant they were taken to the restroom every two hours if they needed to go. But if they needed to go in between, they couldn't go. That was her understanding.

NANCY: I know they do take them between times. I was around. I'm thinking particularly of Bob Bailey. He very often needed to go to the bathroom. He could walk but he could not go alone. And they took him. I could tell when Philip needed to go. He did not say so, but he'd be squirming. I would put the light on, and they didn't know if it was me or the other man calling, but they were right there, and they would help him or change him.

RACHEL: Well, my mother's been at #25 through all of these changes. She's been there three years last May. You have heard the things that are complaints. May I tell you some of the good things? With all the changes that they've had in personnel, with rare exceptions (there are two right now of the whole personnel), Mother has had courtesy and respect and caring. To a proud old lady, it's more important than food. With the turnover they get, I don't know how they choose people who are kind and caring.

Also, most of the time, Mother had not required bed care, but this year she broke her leg and she was ill for about two days in the spring. The administrator called me promptly when he found her ill. She was dehydrated and he said, "We must send her to the hospital." And she pleaded with me, she said, "Please don't send me to the hospital." He said, "You'll get better care there." And she said, "No, I won't. Could I just wait until morning and see if I'm better?" And he let her wait until morning, and she was better. But that night they changed her and her bed completely three times because she vomited and that

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caused the dehydration. I think that was pretty much. Three times in one night, when they are short-staffed.[1]

PRISCILLA: Could I make a remark here? I think that speaks well in a way. In another way it's a very great disadvantage—not to your mother—but when a patient who is that ill is kept in a home, all the other patients are neglected, because *they will not* get more staff. And that's one of the reasons they should be moved. They should be moved out because they will not get more staff.

RACHEL: Well, the reason she didn't want to go to the hospital was because, I think, to justify the insurance payment to the hospital, the doctor has all the tests made that he can think of, and they just test her until they wear her out, when all she needs is nursing care. Most of the aides that have taken care of Mother have been very, very kind.

The worst thing I can think of at #25, aside from the shortage of help,[1] which is as unfair to the aides as it is to the patients, is the mattresses. Three years ago last fall, Ned told me not to buy my mother a mattress, because he was going to put new mattresses on *all* the beds. I bought her one in January, because they still didn't have them, and so far as I knew it's the only new one in the home. The mattresses are terrible!

The nurses rarely see the patients at #25. If they have something wrong the aide tells the nurses what's wrong, and they tell them what to do. The Med Aides see the patients.

NANCY: They don't do that at #26. They tell the nurse and the nurse comes to see, and checks.

RACHEL: The nurse will come some. I don't say the nurses don't come at all. They don't come with any routine at all. I do think the Med Aides are good out there. I'm impressed with how good they are.

NANCY: I didn't think their food was too bad at #25. It was never warm, never hot, but—

RACHEL: They've improved that, though. They have warm pots now, to keep it in.

NANCY: But the food at #26 was excellent. I was invited to have Thanksgiving dinner there, and it was good. And then other times when I would feed Philip it was good. It was never hot.

SHIRLEY: My mother's at #25. On the whole I've been very pleased. She is in a wheelchair pretty much. They try to get her to walk up on a walker about once a day up to the dining room. She spends most of her time in the bathroom, I'm afraid, and that gets to be a problem. They try to get her to go every two hours during the day. And some are very nice about it if she can't. Her main problem is how to work the lights. She'll wake up and need to go to the bathroom, and they'll tell her, "It hasn't been two hours. You'll have to wait."[5] Sometimes they'll say, "It's only been fifteen or twenty minutes," and she will go on back to sleep, and it will be OK. I have talked to them about it, and I think it is better that they try to work on it. Some aides are very nice with her, and some of them just dump you in bed like you are a sack of potatoes. If they could just put themselves in that person's position.

RACHEL: Mother liked Robert. Mother didn't like a male aide, at first, but after she knew him, and he treated her, well, he left her her dignity. Mother preferred Robert after he had handled her a few times. She felt secure. She knew he wasn't going to drop her.

One thing more about #25. Neither of our mothers has to go to the feeding room. But I have observed that they do take people early and they do leave them late. And worse than that, there's a wall that's windows and there's no shades over that wall, and the people facing it have to face that sun. And lots of old people have eyes that can't stand that. For maybe three hours, or near there.

And the woman with the activities is absolutely a darling. She is so good and she is so pleasant, and she makes the patient feel important.

SHIRLEY: There was one thing that Mother was all upset about. Because she was at a table where there were several others whom she would converse with, and their minds were all right. And then she was at a table with several who weren't. And then she would say, "Why can't they put the people whose minds are all right at the same table?"

TINA: My husband was at #27 in B'ville. Mrs. Donna Smith is still the administrator. She was at the time. And she wasn't there all the time. She was the only RN, I guess. Sally Walker was the LPN. And—just like this lady said over here—not enough help![1] My husband entered the home February of 1981. He was there almost two years. And I think that he got as good care as anyone over there, because *I* was there every evening and sometimes other times of day. They didn't know when I was going to be there. But I saw some other things—people that no one came in to see—and I would hear these people hollering for help; and you could look in their rooms and there was a puddle on the floor, and you knew what they wanted.[6] And the aides would sit out there at the table drinking their cokes and smoking their cigarettes and just ignore those poor old people.[7]

Another thing at #27—the first thing that I noticed that I didn't like—of course, my husband, his mind was very cloudy. I would go down in the evening and he would be choking to death for a drink.[6] He would drink five and six glasses of water. And the water in the room was lukewarm. I knew the pitcher was just like I had seen it the day before, you know. And I said something to the nurse about it. I said, "Why don't they give him drinks of water?" And she said, "He's got water there."[8] I said, "Yes, but if he doesn't know enough to get it, he's not going to drink any water." And I complained to the doctor, and he said, "Oh, it's the same with all the nursing homes."

There was this one lady there that they would take to eat. There were about fourteen of them that they would take down to this room in the south end of the nursing home to eat their evening meal. I didn't get off work until five, but other people would tell me that they take those people down about four o'clock and just let them sit there. And they have a glass of water there that's getting lukewarm. And one little old lady in particular that I remembered, she would always reach for her water the minute they brought them in in the wheelchairs, and those aides would just bawl her out. "You don't need to drink that water now. You won't eat your meal!"[8] And finally I blew my stack. I said,

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"Listen, if you ladies would give these people drinks of water between meals, they wouldn't reach for that glass of water the first thing when they get in here."

PRISCILLA: Probably didn't want her to wet the bed.

TINA: Oh, it was terrible. Another thing, my husband at first was able to walk with someone helping. At first, when he was able to walk around, before he was in the wheelchair, they would get him to lie down in the afternoon with his clothes on on the bed to rest. That was fine, but when I would get down there after five they would already have him down to the table to get his evening meal. Of course, they hadn't brought the trays in yet. And there he would be wet clear up between his shoulders. And I said something to them. "Oh, he did that after he came down here." I said, "Don't tell *me* that." And I would take him back—I had to kind of take his hands and kind of pull him back to his room. I would change his clothes and then bring him back down there.[9] And still the trays aren't there. They just took them down there too doggone early, for one thing. Sometimes they left him a long time after the meal, too.[6] They sure did. And one day finally, Donna Smith was in her office, and there was a salesman or someone in her office next to my husband's room. And I just took my husband up there and turned him around and I said, "Now, look here, Mrs. Smith, do you mean to tell me that he got wet like this down there in the dining room? No way." So she came in that time to help me change him, because she knew that I was pretty well riled.

The food in general just wasn't good. I reported it to the Ombudsman. She called me one time on the phone, and she was going to come down and talk to me, and she said, "No, I don't think I had better be seen talking to you." We were afraid, you know, that they would mistreat my husband over this deal.[4] But things kind of picked up. They were a little bit better for a month or so after that visit. There was a little bit different atmosphere. They didn't know who had reported them, I guess. But it was pitiful. That was the only home in B'ville.

They certainly are understaffed in #27.[1] Maybe two aides to look after forty people after the evening meal. Well, I fed my husband at #27 after he got to the place where he couldn't feed himself. And I helped feed the ones all around. Sometimes I'd feel so sorry for them.[9] I would see a big gob of Jello on their plates. There was this one fellow who had Parkinson's disease (he's still there), and he would start to eat that and it would all go on the floor. All right, he had no Jello! And they didn't—that was the thing that I couldn't see—they didn't supervise to be sure that they ate the food that was on their plates and see that they a decent meal.[7]

I know the ice machine down at #27 a year ago last summer was off most of the summer, and I would take a styrofoam jug of ice down there to my husband, because he always loved cold water, you know.

RACHEL: Our patients at #25 have ice water at least twice a day brought to them. Their pitcher is filled and their glass poured while the aide is there to pour it.

WILLIAM: I believe nursing homes are all about the same. My wife has been in #28 in A'ville for over a year. The problems there are apparently about the same as you have been discussing in #25 and #26. One especially, the nurses say they have too much paperwork. It interferes with their time. And I just came from there before coming here, and I had a little surprise. I've been contending all along that they needed a little better system there with their call lights. They only had one in the hall, and none in the room.[3] They're changing them now. The electricians are working on them today.

At times there are enough aides and at other times there are not.[1] And again you will find too many congregated around the table smoking, and they apparently don't pay any attention to the lights.[7]

My wife has arthritis. She's a chair patient. Our experience has been fair. Of course there isn't anything but what can be improved. We're hoping that she will be able to come home shortly. And that will be much better. There's times when they run short of aides—some may quit—and there again for a good performance, I can see their side of the story. Some of them are good, some are not so good. Some are kind and some are rough,[6] and management really has a problem there. And another question, are they working to keep expenses down, or are they trying to increase their income?

PRISCILLA: Management has problems because the owner is the boss. Management really has very little say about how the place is run.

SARAH: I have relatives at #29 and #30, in C'ville. Both homes seem to be rather family-oriented. The administrator at #30 had at least two of his daughters that were on the payroll. I really don't know what they do for the salaries that they are getting. He has a son-in-law, that's working in the office—and when you have families that are really involved, you don't know who you are talking to that isn't related to someone else.

Then in #29, the administrator's son is supposed to be an aide—helping with baths and showers. His daughter works there, and his two nieces. And the Director of Nursing has two daughters that work there. One is the social worker and the other one is an aide.

In the fall I noticed that they have a lot of bugs and roaches at #30 and there was hardly a night that I went down there that I didn't see them in the hallway or on the walls, or even in my cousin's room crawling across the foot of her bed.

TINA: That's what #27 had—a lot of roaches, too.

RACHEL: I want to say one thing, where there's family working for family in a nursing home, they draw better wages than the others.

SARAH: My sister is at #29 and I feel the same things that you have mentioned. They take them to the dining room too early and leave them up too late.[6] My sister has a roommate and she said the other night that at three o'clock, I guess it was, she called them for the bedpan—same old story—they didn't come until four-thirty to give her the bedpan.[6] And then at #30 if you want to go to the bathroom at three or four o'clock in the morning, then they tell you, "Well, you just have to stay up."[6] Or they dress you and keep you up until time to get up.[6]

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RACHEL: That's sadism!

PRISCILLA: That sadism is not in a mild form when people are able to sit up and they are left sitting there for a number of hours. That's very painful. The aides will be sitting up smoking at the table. I used to come back at night to see what was going on, and the call lights would be on, and there they would be sitting.[7]

SARAH: There at #29 several of the residents themselves had said that my sister should have her legs elevated. One resident, she's more forceful, and she asked one of the aides, "Could you help sit this lady up?" And the aide said, "Well, I'll need extra help." Well, of course, the help was twenty steps down the hall in the break room. She could have gotten extra help, but she did not make any motion to do so.[8] And I've gone in there several times and found my sister scooted clear down on her tailbone. And I've asked them, "If you'll take the shoulders, I'll lift the legs, and help you lift her up." And they almost act like it's an imposition.[8] "After all, really, they have too much to do."

PRISCILLA: They want to intimidate you so that you don't ask for too much.

SARAH: And this is what I found out, too, because there for awhile I was employed and I was away during the week, so when I would come up on the weekends I would say to the different aides or whoever was there, "Couldn't you do this?" or "Where is this?" or "Do you have a pillow?" Well, of course they would go right to the head nurse or the administrator or whoever, and she got so that she would call me at home. She would call me long distance and harass me on the phone. She would say that she was going to bundle my sister up in an ambulance and send her to me, because I made too much of a stink.[8]

PRISCILLA: You were being paid back for taking care of her. One place, they called all the other nursing homes and no one would take a man because they had his number. Because he fussed and his relatives fussed, and they had a legitimate right to fuss.

NANCY: Ned Brown, in #25, told me I was harassing the aides.[8] And I said, "I think you are wrong. I always complain when something like this happens to him. And it's going to be taken care of. I don't give a darn, it's going to be taken care of. And anybody else I see that you are not taking care of I'm going to see that they are. And so help me God, you will be punished. You will be. Maybe not now, but you *will be*."

RACHEL: When you are paying for the care they should take care of it. My mother is 93. Her body is all worn out, but her mind is good. I'd rather be hit by a truck.

TINA: A heart attack is a blessing, to go that way.

RACHEL: I thank God my husband died fast. A blood clot hit his lungs. It could have happened to hit his heart and made him ill, and I wouldn't have been able to take care of him—he was a large man. It could have impaired his mind, or so many more things, and it would have broken my heart to put him in a nursing home. And so I thank God many times—I miss him terribly—but I thank God many times that I didn't have to submit him to that.

TINA: Alzheimer's disease—that is terrible. My husband had it for about ten years. The last three or four years it was getting terrible, so I had to put him in #27. We never knew whether he missed anything or not, whether he suffered from that. He didn't know us. He couldn't express what he liked or what he wanted or anything, but I went down every evening and took him extra food, because I knew he wasn't getting enough to eat.[6] He would drink glasses of ice water. As long as he could walk, I would take him to the bathroom myself,[9] but as he got to the place where he was in a wheelchair, why, I couldn't lift him out of the wheelchair, and they would have to take him. Right after his meal he would need to go to the bathroom. And usually they would put everybody else to bed before they came and got him, and by that time it was too late.[7] He did pay attention to television. Anyone who has Alzheimer's, there's something about the motion of that TV screen there that they will watch. You don't know whether they are getting anything out of it, but I know that at times he did, because he would make some kind of an outburst (he never talked ordinarily), but he'd say, "Look at him tearing it apart." Well, it was a dog sniffing out a suitcase that had drugs in it. That was right! I knew he comprehended; he was getting something there. He was only seventy-three years old. I think that it came on him when he was about sixty-four.

SARAH: I consulted a lawyer and the doctor my sister has, and both of them—as you say—said you have to lump it and like it or take them someplace else. And no place else is any better. My sister had mentioned several times there about #29 (we were talking about rough treatment), she said several times, "She beat me," or "She slapped me," and I think some of that's probably one of the aides. And then she also said about them giving her a bath, that they tried to drown her. And her roommate, now, mentioned something too, when they gave her a whirlpool bath I guess they tried to set her on a bathtowel on the bottom of the tub, or something, and it kept slipping and she was slipping into the water.[7] And at #30, my cousin supposedly gets more therapy and walks behind a wheelchair. My sister is not walking any more, and I asked her if anybody comes in and, you know, moves her limbs around. And she said, "No," and her roommate isn't getting the kind of therapy that she should be getting either, because she can't even walk, and she should be getting more rubdowns on her legs.[7] I guess she's got a sore spot or something, and they are not doing that for her.

When my sister was better and could carry on a conversation and could talk more, she said, "What have we done to deserve this? All we have done is grow older." And it's not like a penal institution where they have really done something that makes them deserve a sacrifice like that. Some of these people have coma from rather nice middle-class families, and then have to go into places like this, where you would like to call the aide if you have to use the bathroom facilities! And then they just tell you, "Go in your clothes!"[8] Animals as a rule will try and get out of their own waste, but these people have no choice.[6] I *do* think the staff are arrogant and harass you and put you on the defensive, and evidently the ones at #29 and #30 aren't the only ones either.

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9. Staff tasks performed by visitors
10. Prior knowledge of state inspections

The Kansas Department of Health and Environment is responsible for nursing home regulation.

NANCY: A good many of them are.

SARAH: Because they have the upper hand.

RE: Nursing Home #31 SE

Number of nursing homes in this town: one

Betty did not know who regulates Kansas nursing homes.

BETTY: My mother has been in #31 for ten years. She is now 92. She had pneumonia and she was living alone and I had been on vacation. She had been living with me for about a year by that time with a broken arm that had mended and so she decided she wanted to go back home. I had a home there for her to go to. And so then she took pneumonia and then when I came home from my vacation of two weeks, why, I found her in this position. I was called by a neighbor, which was a very good friend of mine and Momma's, a lady about my age. So I took her to our doctor and for about a week thought she could recuperate from that, which she did to a degree, but was awful frail. The doctor says, put her in this nursing home. He didn't put her in the nursing home, this county lady did, this Mrs. Foley. Now, Momma's immobile. She has to be lifted, put in bed. Can't even turn over by herself. Her voice has even got to the point where sometimes I can hardly hear her. With an enlarged heart, the doctor says, and little bit of everything, arthritis. Hor brain is OK, because every once in awhile I will bring up things of the past and she can tell me.

She sits on her little vessel. They lift her and put her on it. She doesn't do one earthly thing in between, and she is almost blind.

She has had very few mishaps that I know of. They give them physics because they have to, for their bowels, and then if they put on their little call light they don't come until they get down the line.[6] If they don't come when they are supposed to, they say, "Well, you will have to wait until your turn. We are coming down the line."[6] I have heard the girls say this and this is one thing that I really don't approve of.

The little nurse herself came down and was helping somebody who passed away, and Momma put on the call light at half past twelve. And that is a bad time, of course, always after she had eaten her lunch, and I was with her. And I said, "Momma, if I could lift you." I have a bad back, and I can't, and if I was to drop her it would be my fault, and so I have to leave her alone. So I said, "We will try to get someone," then I said, "Here comes the nurse. Bless her heart." And her and I get along just great 'cause anything I want to know, I just ask her when she is on. And she just said, "Give me a hug." And Momma lifted her little arms and I didn't think she would be able to do much but she got her arms around her neck and the nurse just lifted her up and set her on the pot. Just that easy. She put her back down, and she was right there and took care of her.

Momma says, "I haven't even had a bath for two weeks." And I said, "Momma?" I was wondering if it was her mind, you know, I kind of wonder because she can't see her calendar for dates and that sort of thing, and I said, "Oh, Momma, surely." So I went up to the desk and I found out offhand she is slated once a week like she has always been. She had her bath last week and she says tomorrow is her day again. I read between the lines, so that is the reason that I don't do much complaining, because after all at that age, that is wonderful to even be in as good of shape as she is. So that is why I don't complain a whole lot.

Well, again, clothes, they are like they are drug through the creek. They ruin fifteen-dollar sweaters. There is nothing I can do about it. The laundress ruins them. One of the girls grabs them up and picks them up. I put a note in and said, "Please do not put this in laundry." I always took care of Momma's good dresses and sweaters, everything that is good, I took care of. Anything that could go through the washing machine, they are allowed to take. Well, they don't pay no attention, they just grab it up and down to the laundry it goes. And they've lost, I don't know how much of her stuff, just recently, and this is the first time it has ever happened. Here we go again. Her comb, just little immaterial things, a little rubber ring that I had gotten her to sit on, after a terrific fall. It's a wonder it hadn't broken her bones. She was trying to get to the pot by herself. And she was 91 at that time. She will be 92 in the fall. And she fell and hit the stirrup on her wheelchair and knocked three great big chunks in her head and even one little one is not quite healed yet. That was about 7 months ago. She was taking care of herself up till then. She always had took care of herself up till then. And she told me the chair moved and I just took it with a grain of salt. I figured Momma didn't see good. And she just got weak kneed and went down. They found her right off the bat and picked her up and the tail bone was green.

At #31, they don't have a quite full house. Sometimes they have it clear full, but there is two girls on one end and two on the other end or is it just two that takes care of the whole works? I can't remember. But two thirds of the people are immobile. It's a fifty bed home. They don't have enough help. I always have said they haven't enough help since the very time that thing was sunk down in the ground.[1]

I go down there every ten days or so, and sometimes more often than that, and I have for 10 years. And I can shut my eyes and go down the road and every time I go, especially recently this past six months, *new help*. The oldies have quit. New help.[2] Why do they quit? Well, they just pile on and pile on. Maybe sometimes they will have to work a double shift because it is understaffed.[1] Nobody likes that double shift, not for no three dollars and whatever it is.

The help, they give them their ice water and of course they can't handle it. Mother couldn't pour herself one and hasn't been able to for many, many years. I don't know whether they give her a drink or not. If they give her medicine and pills and all that kind of stuff, of course they always have their water right with them in their little cups, you know. And at their mealtimes there is always plenty of liquid. Their coffee if they are a coffee drinker, their milk, their water. It is always on the table. The food, as far as I'm concerned, it has just absolutely come up 100%. I am so pleased with the food, I really am. The girls are such good cooks. I know when Momma first went there, I know that she went to bed at night hungry many times. Then, I always took her fruit and stuff. And she had crackers and little cookies and stuff always to nibble on and if she hadn't of, she would have went to bed hungry many times. But the food had improved quite some time ago. I wouldn't know as to how long.

I have compassion for the help, because they have everyone come in there with different lifestyles and

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different dispositions. One lady there, if she was a patient of mine I would spank her. She is the hatefullest human being and I said, I told the little nurse, I said, "Well, you didn't get her medicine down her, did ya? She didn't need medicine, she needed a spanking." And she just rolled her eyes up at me and a grin come around and never said a word. And I thought, "No, bless her heart, you can't say it but you were thinking it." That lady was born with that temper and disposition or she wouldn't have done what she did.

There is nobody on earth that has a disposition that could be any more fiery than my mother when she was young. A little bit of French, a little bit of German, and a little bit of everything around up there and a temper like a buzz saw. My mother used to have this fiery disposition. Lord, now everybody down there said, "We love your mother." They say she opens her mouth just like a little bird and down it goes. Just as mellow and has always worked. She worked until she was 80 years old with her hands but then her eyes got to the point where she couldn't see and had to give up all of her knitting and all of the little things that she did with the home as far as decoration, and all that jizzy-jazz.

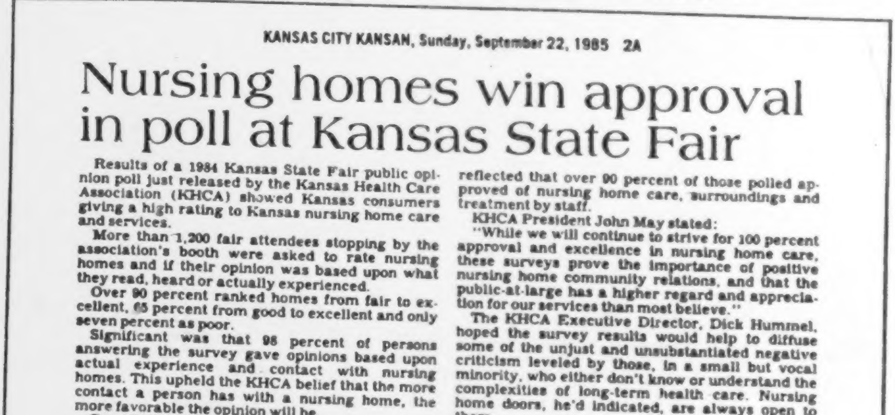
One problem at #31 is the few that I feel belongs in Osawatomie. There is one right next to Momma that I have heard her scream at the nurses when they went to give her a bath, "I'm not gonna take a bath. I'll pull them glasses off of your face and I'll stomp on 'em." She says, "You think you are so smart", and on and on and on. And this is what the girls have to put up with. And they are afraid of her. The cleaning girls all wait till she goes to dinner to clean her room. Momma's roommate, when she was at herself, she was one of the wonderfullest people that ever was. She went berserk and they took her out and she was out for a long time. And, lord, I didn't think the poor soul was gonna live. She was in such bad shape. And I don't know how many years ago this has been and now she is back in again with Momma. My heavens to Betsy, she is 15 or 16 years younger than my mother. She is a nicer roommate now again. They brought her back in because you see she don't bother nobody. She just sits there and then they put her in bed. They brought her back again with Momma because they have had many, many, many that were awful, awful hard to get along with. Now, she just sits there. She doesn't even know her own name. I always pat her and talk to her because I've had so many, many good conversations when her husband was alive. And they were just all over the United States and I've been a globe trotter. So, we had a lot in common, and we would just sit and talk and talk and talk. Now, she doesn't know her own name and hasn't for years.

Another thing that bothers me is really like losing things, their clothes. You go down there with lovely clothes and half the time then you can't find them. They are in somebody's else's drawer and when I found a half a dozen things missing in mother's drawer and that she needed, then I went to the nurse and we found them down in the laundry room, and in somebody else's room.[7]

I don't think they have anybody in their employ now that what looks like they would be smart enough to, really and truly the help they got right now, I don't think quite, well—

There are about four or five at different times when I go down on their shift that has been there quite sometime. But that is about all. The other turnover will be—a lot of it is night turnover.[2]

One thing I want to say. Those aides are understaffed, overworked, and underpaid. They know their job—they take that course, what I call a crash course; about the time they've got it down pat, they'll stay a month, and zip! They're gone—to better paying jobs.



KANSAS CITY KANSAN, Sunday, September 22, 1985 2A

Nursing homes win approval in poll at Kansas State Fair

Results of a 1984 Kansas State Fair public opinion poll just released by the Kansas Health Care Association (KHCA) showed Kansas consumers giving a high rating to Kansas nursing home care and services.

More than 1,200 fair attendees stopping by the association's booth were asked to rate nursing homes and if their opinion was based upon what they read, heard or actually experienced.

Over 90 percent ranked homes from fair to excellent, 65 percent from good to excellent and only seven percent as poor.

Significant was that 98 percent of persons answering the survey gave opinions based upon actual experience and contact with nursing homes. This upheld the KHCA belief that the more contact a person has with a nursing home, the more favorable the opinion will be.

Correllating to the state survey was a recent national Roper poll which showed that the more community involvement a nursing home had, the higher the community and public regard for it.

A 1976 U.S. Census Bureau report on institutionalized persons, based upon interviews with nursing home residents and their families, reflected that over 90 percent of those polled approved of nursing home care, surroundings and treatment by staff.

KHCA President John May stated:

"While we will continue to strive for 100 percent approval and excellence in nursing home care, these surveys prove the importance of positive nursing home community relations, and that the public-at-large has a higher regard and appreciation for our services than most believe."

The KHCA Executive Director, Dick Hummel, hoped the survey results would help to diffuse some of the unjust and unsubstantiated negative criticism leveled by those, in a small but vocal minority, who either don't know or understand the complexities of long-term health care. Nursing home doors, he'd indicated, are always open to them.

The Kansas Health Care Association (KHCA) represents 250 licensed adult care homes and 18,000 nursing home beds in Kansas.

The KHCA has conducted another survey at this year's State Fair in Hutchinson and the results will be released later in the year.

[The Kansas Health Care Association is an association of Kansas nursing homes, mostly profit-making.]

END.

KINH News
KANSANS FOR IMPROVEMENT OF NURSING HOMES, INC.
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SPECIAL SERIES
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INSIDE KANSAS NURSING HOMES

RE: Nursing Home #32 SE

Number of nursing homes in this town: one

Frances did not know who regulates Kansas nursing homes.

FRANCES: My mother entered #32 eight months ago. As far as the nursing home itself, it's just beautiful. It is a showplace and of course this is a small town. But it's very misleading. Now, they've got some exceptional and some very good floor nurses there. But your problem is at the *top*. Some people in the community put money in originally, when it was built, and they got government funds.

The LPN is the Head Nurse, she's in charge. She just absolutely does nothing as far as administrative, you know, she does *nothing* as far as supervising the nurses.[7] She's a likeable person, but she just ignores everything. The first thing she did was move her office clear back where she can't even *see* what's going on. If you go in and you say something to her about the care of your relative, she'll say, "Oh, yes, I'll write it down." And she never, ever passes this on. There's no chain of command. She writes it down and nothing is done about it. For example, my mother was supposed to have fluids forced on her, and I went up there after our help was gone, during the evening, to see that she drank liquids. And one of those nurses looked at me and she said, "What are you doing?" I asked her, "How many cc's are in this glass?" And she said, "I'm not sure, but I'll check and see," and she said, "What are you doing? Are you keeping track of her fluids?" And I said, "Yes." And she said, "Well, it's nice to know." She said, "It would be nice if someone would tell us that." See, the doctors give orders like forcing fluids or something and nobody is *told*.[5]

This Head Nurse has no idea what the care is supposed to be, and she couldn't care less. You just keep telling her over and over and over, and nothing is done. And, for example, I know when they are supposed to be turned, why, they will have charts up there on the wall that they are supposed to be turned every so many hours, and they don't turn them.[6] There is nobody who checks to see if the floor nurses are doing what they're supposed to do.[7] And nobody *tells* them what they're supposed to do, either. They can't help but know they're supposed to turn them. However, from five to eight they're very short-handed.[1] There's *no way* that they could turn them every two hours. This one woman who goes up there and helps take care of her husband, she came back at noon to feed him, and he hadn't been turned.[6] She said she reported it like she usually does, but it doesn't do any good. Now, they have that chart in there, they're supposed to check; and she said they went in two days later, and when she went in there she saw they'd gone back and checked that chart over as though they had turned him.[5] One day they went in there, one aide did, and just walked over to her husband's bedfast roommate and checked his chart as though he'd been turned, and walked out.[5] That's not just one person that's doing that, because she's on in the evening. The same thing is happening during the day. But the thing is that that man weighed under a hundred pounds, and she could have turned him by *herself*.[7]

One day my mother saw this. The aide came to answer my mother's roommate's call bell. She needed the restroom, and she walked over and she told her, she said (this was at four o'clock), she said, "We don't put you on the commode until after supper."[8] That would have been at six-thirty. And then she walked out and turned the light off,

The Kansas Legislature Can Do It! (*if* we ask them to)

This issue is the sixth and last in Volume I of the KINH Special Series Newsletter. These six issues have consisted of consumer comments on forty-two nursing homes. These comments make abundantly clear the physical suffering some homes are inflicting on their patients, and the mental suffering endured by their relatives.

There are, of course, good nursing homes in Kansas, as well as poor. It may be possible to estimate the proportion of adequate homes to inadequate when we have heard comments on a greater number of the state's three hundred and seventy homes. KINH plans to continue publishing consumer comments in forthcoming issues of Volume II of the Special Series.

We deplore the continued existence of nursing home neglect and abuse in spite of our lobbying for better nursing home legislation at every session of the Kansas Legislature since 1976. Some have accused us of "spinning our wheels", and to the casual observer this may appear to be the case. However, our best efforts have been hampered by the undeniable reluctance of the Legislature to initiate meaningful change.

If Kansas physicians should decide to use their very considerable influence to lobby for improvements in nursing home care, this reluctance would melt away like ice under a heat lamp. Unfortunately, physicians and the organization that represents them at the Legislature, the Kansas Medical Society, have so far chosen to ignore nursing home problems.

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and mother's roommate absolutely filled the bed.[6]

From five to eight they are terribly busy. They are short-handed, and you cannot go up there and say, "Well, now, they don't turn them," when you realize they're short-handed.[1] This goes back to the Head Nurse, she is the one that plans out the schedule, and she's up there during the *day*. They're terribly short-handed in the evening, and I don't think they are that short-handed always during the day.

One day I looked at our aide and I asked her, "I want to know something. I want to know what kind of care my mother's roommate gets during the day as far as bathroom." And she said, "Well, one day they told her, when she said she had to use the bathroom, that she had a diaper on, to go in the diaper."[6] I do not report anything like that unless I know it's happened other places, in other rooms. So I called this friend whose relative is a patient there, and I told my story, and I ran the whole story by her. And she said, "Well, many a time they told my husband he has a diaper on, to go ahead and go in the diaper. They told him that while I was standing there."[6] And I was just horrified, and then she started in, and I guess she thought if I wanted to hear, you know, tales of woe, that she'd tell me. And she told me some of the experiences she's had, and I'd never heard anything like it.

Now, I was also up there in the evening and it just happened to be when they put Mother's wing to bed. And there was a woman across the hall who had to be put to bed. And they put her to bed in six minutes. She was poseyed in a wheelchair. They did not take her to the bathroom.[6] But now, as I told you before, this is five to eight, and they don't have any choice.[1] You've got some real good help during those hours, but they've got only so many people to do the work, and they've got a lot of them to put to bed.

Before I forget, too, there are a *horrible* number of catheters in this nursing home. They get poseyed in a wheelchair, then they can't go to the bathroom themselves.[6] Then they become incontinent. Then they get bedsores. Then they put the catheter in for the bedsores. Well! And it's all premeditated.[7]

The sad thing about it is they *know* when the inspectors are coming. They don't know the exact day, but, you know, for weeks up here they are cleaning this nursing home up before the inspectors. The reason I've known this for years is because my mother had a very close friend up there. She used to visit with her on the telephone, and she'd say, "Boy, they're really working up here. The inspectors are coming."[10]

Is there any possibility of getting the Legislature to *make* them, when you check a person into a nursing home, give you a list of the rights of the residents, even if they change them some?

The last Head Nurse quit because she kept complaining about things up there, and they didn't do anything about it. And then also she frequently worked on that evening, that two to ten shift, and they were short-handed.[1] The schedule that she figured out, they only had five minutes to feed them, and only so many minutes to put them to bed, because they're that short-handed.[6] She was very conscientious and she's very good, and when you go up there and see those old people neglected, she said, "I'd go home at night, and I couldn't sleep!" And this is the type of people that we have—the floor nurses up here—that are leaving. She was *really* good, and she had others up there working with her that were the same way. And, you know, they can drive to a town near us and get a job as a secretary—the women can—and not have all this hassle and have better hours. And the funny thing about it is, they don't *try* to keep the better ones there.[7]

AMELIA BRENT: My mother died two months ago. She had been in #32 for two years. I was very unhappy about the care, but they got a new administrator, Dora Jones, three months ago and the care improved immensely. She has had some unhappy people working for her because she has insisted on things kind of coming into line. They had never done anything excepting for what they wanted to do, and so they were real unhappy. Most of those aides are gone. As far as I'm concerned the care has improved. I don't know about anybody else because all I have done is go straight to my mother's room. I fed her three meals a day,[6] because no one had time to take that much time,[1] because it would sometimes take an hour and a quarter to feed her. They don't have that many people working. One of my daughters is an LPN and I read lots of her books, and I read that people should, if they were blind, be told what they were being fed. And should be helped in any way you could. And like I said, when they had two or three on a corridor taking care of everybody that was on that corridor, there simply was no time for them to do that.[1] A few months ago, I had to be gone for a little bit. There was a death in the family. When I came back, I said, "How did she eat?" and they said, "Oh, she ate everything on her tray." Well, I know better. I knew it took too long and I knew she didn't always eat it all for me.

Mrs. Jones couldn't increase the number of aides. There have been so many expenses after the place has been open for fifteen years, all the things that need replacing, and there was not that much money to do things, so she has been working on a shoestring. But I do feel that she is doing her darndest.

Before Mrs. Jones came, they didn't used to keep my mother clean. Early in the morning, I would find the bed soaked clear down to the mattress, that sort of thing,[6] but that hasn't happened for months. Mrs. Jones got rid of several aides. That helped. The LPNs that she had or has, I can't think of a one of them that doesn't try pretty hard.

About giving her enough to drink, that's probably up for grabs. They would tell me that she drank enough because they gave her supplemental feeding twice a day, and they told me she would drink water afterwards, but you know I can tell when she didn't because that stuff was still in her mouth. If she had had water, it wouldn't be.

If I were unhappy I said so. If she were at home I would have taken care of her, but I couldn't lift her. And she had to be lifted for everything. The last week she was at home I carried her on my back to get her to the bathroom. And I'm 65 years old. There just wasn't any other way. So I *had* to. I said I had to come to this kind of care. She hated every minute of it. She could say only a word now and then, but I could practically read her mind. She seemed to know everything that was going on. She couldn't tell me who had been there, but I would go over the list of who might have been, and when I got to the right one, she would nod her head. She slept so much of the time, and I just thank God for every minute she slept.

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The administrator before Mrs. Jones was nice, but she did not know what to do about anything. I asked her one time and she said, "Well, the nurses, you know, are not my concern."[5] She said, "I have nothing whatsoever to do with the nurses. The girl who is in charge of the nurses is in charge of the nurses. If I hear something I tell her but I can't force her to do anything."[7] Now the head nurse is Margaret Preston. She has been there for quite awhile. She's a likeable person. I've known her since she was a tiny girl. And I like her but she is not a boss. You know, it takes a certain type. She is not a real good boss. She's got Mrs. Jones over her now. And I do believe Mrs. Jones is riding a tight herd. She has worked in nursing homes for about ten years but I don't know where. She is good. She is up there late in the evening and you see her up there on Saturday. You see her up there part of the time on Sunday. She spends her whole five days during the week, too.

The biggest problem with aides is absenteeism. One of the girls told me that they were trying to teach the new administrator a lesson. And I said the biggest lesson they'll learn is that one of these days they'll get fired. They didn't want somebody telling them they couldn't do this and that they had to do this. That low pay they get, that is a sinful thing. They can't even afford to buy their own shoes, when it comes right down to it. Most people get over minimum wage. They get a whole 10 cents an hour more, I understand. This last time when they raised the rates, I said, "Well, will the girls on the floor get any of this?" And they said, "Yes, they will, this time." And I think they gave them 35 cents an hour on top of what they were getting.

RE: Nursing Home #33 SC

Number of nursing homes in this town: over fifteen

Excerpts from letter received by KINH from Al Chase:

The care in nursing homes needs to be drastically improved. My brother, Sandy, has been in two nursing homes in this area. Several months ago he is supposed to have wandered into another room and have fallen.[6] A male aide came to work on second shift. He tried to get him out of bed for a walk and found he could not put any weight on his left leg. The aide had not been told about the fall.[7] The next day, about noon, the staff at the nursing home called to tell us he had been taken to V.A. hospital because he had hurt his foot. When we got to the hospital they had x-rayed him, found a broken hip; 4 different breaks. They bolted the thighbone to the bone because they could not use the steel ball, and put a steel strip over the break. When he finally recovered sufficiently to go back to the nursing home, the doctor wrote a 5 page instruction order for his care. We were not allowed to see the instructions, but we are sure the instructions were not followed. Since then we have found him completely soaked from waist down a number of time.[6] When I inquired why, the head nurse told me all his pajamas were in the laundry.[6] He is supposed to have 6 pairs and at least 3 pair were in his dresser drawer at the time. He needs to wear a pad, furnished by the V.A., but when we find him without pajama pants on the bottom half, he has no pad. Of course, he needs the bottom half of pajamas as underwear to hold the pad in place. He needs the pad because he has lost control of bowels and bladder; without the pad, he has to lie in the mess.[6] We also found another patient, who is a friend of ours, lying in bowel movement mess.

At another time an aide brought his lunch to him, set it down in front of him and started to leave. We asked whether she was going to feed him. "Does he need to be fed?" was the reply.[7] At another visit, another aide brought in his food, again set it before him; he grabbed a plastic cup with ice cream and took a bite of the plastic cup and started to eat the plastic.[7] Again we had to tell the aide that he could not eat by himself. Both aides were untrained and had not been told condition of patient.[7] Is that on-job training? Time after time we find a glass of milk standing on the dresser, warm and not fit to drink. We wonder how often that happens with his meals.

The laundry is run by untrained help, for clothes are ruined by bleach; some are lost. House shoes disappear as well as other clothes. Other patients' clothes get into his dresser. They are all marked by patients' names. I guess the aides can't read or don't care.

It seems that management is more concerned to hire people from the class of people where they can claim 50% of their wages as tax exemption. The program of on-the-job training is fine to train a person how to repair a motor, but to have them practice on helpless patients is not fair. They are human beings. It seems that the aides are not trained before they are to take care of patients and not even given information on the patients they are to take care of.[7]

Additional comments in interview with Al Chase:

My brother's rate has gone up $1000 a year. Their plan is to raise it every six months, two dollars a day. I'm pretty upset about this rate. It's just going up and up. We'll have to go to SRS; he's a private pay patient now.

My brother seems a little cleaner now, but I think he's pretty well sedated. There's a panty-like thing they can put on, all they have to do is to go to the VA and get them, and when they have one of those on him, he is protected; it doesn't get all over the bed. They didn't use them when they first brought him back from the VA Hospital. They just left him lay, naked, just naked, not even underwear.[6] I'm not sure whether they are using them now or not.

At Christmas, we bought new pajamas for him and new house shoes. Well, his things are gone. Things just disappear. The help, there's so much turnover, you don't know who's responsible for what and I've just quit trying to communicate with them.[2]

Yesterday, at my doctor's office, I saw a lady who used to work there in the nursing home and got to handling my brother real well. I hadn't seen her there in a while, and I said to her, "Dotty, are you still at the home?" And she said, "No, I haven't been there for a year. I just absolutely couldn't get along with that Mrs. Hill." That's the administrator, she's been there for many, many years. She sort of, to me, pushes people around. She's for the management, of course.

My brother can't get on his feet any more, since he broke his hip. As far as I know, the only time they get him up is to eat. As long as he can move a little bit in bed, he won't get sores. And his bedding and he himself seems a little cleaner and he seems a little bit more calm, but I think he's just wearing out.

Things have improved a little bit, I would say. There's very few staff people around in the home. When we go up

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1. Understaffing
2. Turnover
3. Potentially life threatening
4. Fear of retaliation
5. Non-compliance with state regulations
6. Neglect and/or abuse
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there to see him, there's nobody around, but the minute we go in there to see him, here comes somebody, a staff person. Here they come, and either just walk in and look around, I guess to see what we're doing, or to see if he needs changing. They know we've raised thunder enough about that. Things go on pretty much as has been.

The whole nursing home set-up is a disgrace to this country. And there's more and more old people, and it's just pathetic, just pathetic. It's wicked, really.

RE: Nursing Home #34

Number of nursing homes in this town: over fifteen

Excerpts from letter received by KINH from Bonnie Dickinson:

My mother has been in nursing home #34 since May, 1984. She is mentally disoriented, somewhat paranoic, and has several physical disabilities. Since admittance to #34 mother has lost twenty pounds in three months.[3] She was walking with the aid of a prosthetic cane; she no longer can walk without two people assisting. She was continent when admitted, she is incontinent now.

Despite the doctor's orders, a large sign in her room, my purchase for some time (2 months) of Depends and finally the administrator's assurance that a diaper-like device could be issued free, the aides do not put them on her, and she now has sores on the buttocks.[6]

The "do-nut" pillow I took is used inconsistently. The last time it was missing for two weeks and the rubber form finally was found by a charge nurse locked in a room. The clean cover was in mother's closet.

She is at times left naked from the waist down.[5]

I do all her laundry which I pick up two to three times a week.[9] The clothing is not only urine soaked, but they also leave any lumps of feces in the clothing.[7]

Her teeth have also had to be found at times.[9]

Her hair is not washed and set once a week as I have left orders for.

I take her something to eat and drink every time I go to see her, which is always devoured.

Her water pitcher and glass are not within reach so that she can use them.

The first 2 or 3 months she was so heavily medicated from Haldol and Thorazine that her head was pulled into her shoulder.

Since I complained about this she is some better as far as head posture but is now very vocal and demanding.

Recently, her eyeglasses are gone and up to this letter date have never been found.

What one of us would not be vocal, irascible, demanding, frustrated, uncooperative if we could not see, hear, eat or were hurting from pressure or bed sores and lack of human care or response when needed, or left without any dignity or body covering and restrained 24 hours a day?[7]

The restrainment was necessary after her condition worsened drastically in such a short time.

I learned in a short time that her better clothing could not be used since urine wet clothing and dry clothing, even wool jackets or sweaters, bedroom slippers, etc., all are put in one plastic lined hamper. This is done despite my large printed sign on the inside of her closet door, "Please hang dry clothes, and place *only* wet ones in hamper."

I tried at first in any way to cooperate with the administrator and employees.

The administrator gives me "milk-sop" answers which are meant to pacify but only infuriate me since cover up stories are an insult to any mature mind or any reasonable intelligence.[8]

Their answers are:

1. She throws things. (How far can an 85 year old wheelchair or bed-bound person throw anything that cannot be found within the confines of a resident's half room?)

2. She probably knocked them into the waste basket. (A small waste basket inconsistently has been in the room, but not within her reach. The other resident's basket is used to prop the door open.)

3. Everything could possibly have ended up in her bedclothing. (Then why didn't an aide find it when changing linens or the laundry room discover it?)

There is no feasible way I can take care of her. My husband in the last six years has had a heart attack, by-pass heart surgery, an aortic graft for two aneurysms in the abdominal area and in June of 1984 had a kidney stone extracted, with a large stone to be removed on the other side in the future, and is going to retire next year.

Unfortunately, my mother's physician moved to the northern part of the state at the time I moved her to the nursing home. So, no one taking care of her medically knows her as she was.

There have been unexplained bruises.

In July I was called by the charge nurse on a Sunday and told my mother had fallen but that she was not hurt, only bruised and the doctor had been contacted.

The doctor did not make a visit in person, only took the nursing attendant's word.

Her bruises (I wish I had had a camera) were from the waistline to half way between the knee and hip joint and extended from the front of that area around to the middle of the back of the leg area.[6]

Another time in August, I went in her room for a visit and to return clean clothes and take soiled ones with me, she was being picked up from the floor by a male nurse. On the floor in approximately a 14 to 18-inch diameter circle area was a bloody discharge. I was told after a visual exam by them that there were no injuries needing attention.

Everyone there, except a few, act as if I am doing them a great disservice to bring these things to their attention.[8] The attitude is that I am wrong about the happenings. There is a distinct air of lethargy and apathy.

I was told by the administrator at the first that of her 82 employees they *possibly* could not all be trusted. What kind of sadistic characters would take medical needs such as glasses or hearing aids from a weak, sick and defenseless person?

My mother not only is missing these and material things that she relished, treasured and took pleasure from, but I am reduced to frustration and anger and a loss of peace of mind.

She should have some quality of care and comfort before the last stages of her mental problems, because she has at times an awareness that shows me she is cognizant of what the conditions are.

All of her treasured memories are gone; only the day to day happenings remain. Somehow she does know I will be there when I can and that I bring her something good to eat and that she can hear when I place the hearing aid in her ear.

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1. Understaffing
2. Turnover
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Only five months ago I took her for long rides and a special luncheon once a week.

There is nothing in *this* life left for her to enjoy, only a possible easy passing on to where her faithful, and as she called him, "beloved husband", is. And that she prays for, I am told by her roommate.

Is this what some of us have unknowingly to look forward to in our later years?

Is there not some way we can change this so that our elderly handicapped could have a benign atmosphere at the end instead of an animalistic type of superficial and inconstant care?

Additional comments during interview:

BONNIE DICKINSON: The help is very incompetent and below grade in terms of sanitation. They don't wash the patients. If there is a hand washing sign in the room for them to observe, they totally ignore these things. They go to the patient and, perhaps in wiping feces off and with that on their hand, they go ahead and attend to other duties with the patient.[6]

You have no way of proving whether bruises are from a fall. Perhaps the aides become a little unhappy. I have seen gestures of unhappiness on the part of the aides. They turn around with disgust on their face and swing their arm out like "I have *had* it with you!" And there are other things, too.

There is not enough help to feed these people.[1] I have an idea that while my mother's eyes were bad this week from the heavy cold and inflammation she had in them that she was unable to see her food and feed herself properly. She was ravenous by the time I would get there with milk and soup for her. I take jello, fruit, anything I can think of that she can chew because they lost her lower teeth in the last month.[7] I have often felt that if they'd let the high wax floors go, up there, and if they would possibly pay for one more employee for the care of the patients,—the residents cannot walk on these waxed floors. As long as the inside of the residence is kept clean and sanitary, the wax could go. I think it is for the impression of the outside public that come in.

They bring ice in the room. They are very faithful about bringing it in, sometimes they leave the ice that forms in one big chunk in the thermos and the patient cannot get to the lavatory to put water in it. A lady across the hall from my mother the other day asked me if I would come in and fill her jug up for her.[9] They never came back and put water in it.[7]

Mother has donut pillows. She has fleece formed into seat pads. She has everything to work with but they don't take time to put it in the wheelchair or on the bed. And she sat and laid in urine and feces long enough.[6] I started warning them at least 2 to 3 weeks ahead of time that they were going to have some beautiful decubitus sores if they did not observe her sanitation closer and keep her dry. That finally split into a place about 2 to 2½ inches long and finally a staph infection was involved in this split,[3] which takes a lot more time to doctor than the preventative measures, if they would use those in the first place.

It is just pure ignorance, a low quality of employee who has not been versed in sanitation. They get so busy that I don't think they train them properly. I could go on and on.

I think one of the most serious problems is the lack of sanitary care, which comes from the type of employee they have, the lack of time to train them, or watch them, and oversee how they take care of the residents in the home.[7] It seems to be, I've noticed with the new aides, they come in and they seem to be more or less dedicated for awhile to their job. And then apathy and lethargy seeps in, and finally it gets down to the point of it's an attitude of "I don't care. I have done what I should do. I *did* fill the water pitchers. I *did eventually* go in and clean up the person." I have seen mother with feces around her fingernails eating her food in the dining room.[6]

I carry Efferdent tablets in the bag that I take up so that I can keep mother's teeth clean because my mother was a very clean person.[9] Her personal habits were beyond reproach, but I have seen her teeth so discolored and with food particles on them, that it would disgust people that do not know her or that wouldn't have known her before.[6] Of course, there comes a time, too, when you have to have a little personal daintiness among these people to raise their morale, such as the beauty salon. I know it doesn't seem too important to some, but I think it is a very important factor. In the last 3 or 4 months, they have totally disregarded taking care of mother in that fashion even though I have left notes, requested it. They just *don't* do it.[6]

RE: Nursing Home #35 SC

Number of nursing homes in this town: over fifteen

CHARLES RIGGS: My grandmother was in #35 for about two weeks a month ago. I believe that place ought to be closed. It's filthy.[6] Very well understaffed.[1] And the people they do have on staff are incompetent. This was told to me by some of the nurses that I know here locally. That they wouldn't have anything to do with it. I just can't stand it. They force fed my grandmother through those tubes in her nose. I went up one night and she was in bed and she was already aspirating.

When they got her out of there and sent her to the hospital, they said it was just a matter of time. At the hospital, she laid over there for twenty-one days with that tube down her throat so she could breathe and they brought her out of it. I mean they tried new antibiotics and everything. She was completely in a coma there for twenty-one days. She came out of it and we would not take her back to #35. In my terms, I just call it a meathouse.

When she was admitted to #35, she was very incoherent, you know. I would go in her room and she would be uncovered.[6] She would be laying outside the bed, her arms out. You would have to move her back in and put her in position. And I would finally go in and raise Cain with the nurses or the aides, whoever it was. They didn't really say anything. They just acknowledge you and go on about their business.[8] They've made the remark that they are understaffed also.[1]

What I would want to do is just close them down.

She would be laying there in the nude, uncovered.[7] To restrain her they would tie her in bed. Well, finally they never hardly loosened the restraints. They did that because she kept scooting around and I would go in there and her arms would be hanging out of the bed or her head would be laying off over the side of the rail.[6]

What I would do, I would go there at nine at night, just to check on her welfare, and she would still be in the same situation.[6] And these people don't like you around late.[8]

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1. Understaffing
2. Turnover
3. Potentially life-threatening
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They want you to be there 8:00 to 4:30. But they never told me that, you know. I checked on her at various hours and that is the only way to see if a person is being properly cared for. I was there with her and they tried to reinsert one of these tubes down her nose. Well, I was in there with the nurse, and I said, "Stop it, stop it." She said, "She pulled a small tube out." They tried to put a larger one back in. I opened her mouth and that tube is coiled around the inside of her mouth.

They don't have any expertise.

I would take a syringe and I would put it on the side of her mouth. Like 2 cc's or 5 cc's, and she could swallow that. It was one of the nurses who showed me how to do it. No one else wanted to.[8] I took it upon my own.[9]

We were coming home from a party around midnight and that was when I stopped and found she was aspirated and coughing, and I finally went down to the nurses' station and she said, "Well, if she gets any worse, we'll get hold of the doctor." Well, apparently during the night, she just almost died, so they called an ambulance and took her over on that Saturday morning. Like I said, she was there for twenty-one days. Just from their damn neglect, is what it was.[6]

After that, we transferred her to private pay Nursing Home P. And she got terrific good care out there. I checked there in the morning and I checked there at night and you know, there at #35, she would just lay there in her own feces. They could care less. I would stop there and I would make them clean her up.[6] In fact, I even cleaned her up a couple of times myself.[9]

When grandmother was at #35, there was a poor old gentleman there I had known years ago. I tried to help him when I would go in there. He had a urinal and they would never dump it for him.[6] He couldn't get in and out of bed and take care of it. So I would go in his room and dump it for him[9] and the last time I was there I told him, "Why don't you just take that damn thing and throw it against the door?" I said, "That will get someone's attention."

Nursing Home P was marvelous, but #35 is nothing but just a holdover place waiting for them to die.

RE: Nursing Home #36

Number of nursing homes in this town: two

SALLY OSBORN: My cousin entered #36 two years ago this last October. She's in a wheelchair. She's completely dependent. She is eighty-seven; she'll be eighty-eight on her next birthday. She is very hard of hearing, so she's pretty well shut out of everything, and is almost totally blind. She can't see to do anything. She can't read, she can't see to dress herself, she can't do anything, but her mind is good. Now, I went there the other morning at breakfast time. She was eating her Post Toasties with a *fork* without any milk on them, and there were girls helping others to eat their meals all around.[7] They couldn't help but have noticed if anybody cared. So I poured the milk on the Post Toasties and gave her a spoon, and she was able to eat them, but, of course, most of her Post Toasties were out on the table.

A year ago about this time, I went in there and she didn't have any stockings on, didn't have a thing below her waist. It was just a summer dress above her waist, no sleeves.[6] Well, consequently, she comes down with a terrible cold, and had all of this phlegm, and she was very ill before Christmas time last year about this time.[3] There's been other times she's been like this, and I have complained. But then now again recently I went in and she just had a summer dress on. No sweater and no lap robe over her lap, sitting in her wheelchair.[6] Now, just this last week I went to the administrator again. I had gone in there and there she was with just not a thing, now even stockings on her legs sitting in the wheelchair, and with a summer dress on.[6] And she had six pairs of these warm-up socks with the high tops in her drawer. When she wears silk stockings they pull them on so tight on their feet that they just curl back their toes, so I have her wear warm-up socks. Warm slipper boots, you know. That was just the other day. I write it down on a calendar, all these things. This was just last week, or maybe it was this week. So I went back and, of course, the administrator writes a little note and puts it in on the head of her bed, but it's written in such small print I don't imagine that any of the aides see it.[7] Now, I went in there the other day. It was after eight o'clock, and she's still in bed in the morning. And they put them to bed just soon after supper. I've been there at 6:30 and they've been in bed. What I had complained about, really, really complained about was about a year or so ago they raised her room rent. She has a semi-private, but the thing of it is she had *had* a broken hip, and she had been disoriented, and she had to be fed and was far more care than she was at this time that they raised her rent, but they said that she is older now and is more care. They say that she's incontinent. Well, she *is* incontinent because they have her poked off in her room by a window without any way of letting anybody know anything, and never come see her.[6] She could ring if they had a bell, but they don't. I suggested that they get her a bell, and they said they would, and they never did. They do have a call bell, but it's not where she can reach it.[9] And all they have to do is just automatically take her to the bathroom.[7] When I'm there or she's out here we have no problem at all. Just automatically three or four times during the day, before a meal and after a meal, we take her, and that's all she needs.

At one time, it really helped her, they put the patients in their wheelchairs around the nurses' station. But now it seems as though the fire or the insurance says that's a NO-NO, so they are stuck back in their rooms. And at the time that they were raising her rent, they hadn't touched her teeth for months.[9] I had to go in there and take care of her teeth, and I have to clean her eyes.[9] Her eyes would be all matted shut. And they'd just be so matted shut every day I'd have to go in and clean her eyes.[6]

I told the administrator that I had to do all those things. She says, "Well, there's not a thing I can do about it."[9] And then talking about raising the rent and so forth, she was supposed to be getting therapy. I mean, they have all these things that they pay for. She sent one of these things out that has all this on what they're doing for her, and there was so much of it that they were *not* doing. Like, for instance, taking care of her teeth and all of this therapy. Well, she was not getting any therapy whatsoever. So I told them I wanted to be there when their therapist came in. So then they and this therapy fellow came in to evaluate her, he said, "Can you raise your feet?" And she raised her legs, and that's it.

He takes her and walks with her out a little bit with the help of another therapy girl that works there and walked

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back, and that was it. She doesn't even get that therapy. She doesn't even get that. She's supposed to, but, see, they don't do it. They're supposed to have girls there that this therapist tells them what to do. They're supposed to do it, but they do *not* do it.[9] And so I always see to it now. I always see to it. I park her wheelchair back in her room, and I see to it that she walks with a walker to the bathroom every time I'm there.[9] And I try to be there every day, but there are lots of times that I can't be there every day. But do you think I could get the aides to make her walk to the bathroom and back? That is impossible. They have to take her right to the stool and wheel her on and wheel her off, and so you see she gets absolutely no exercise whatsoever unless I'm there.[7]

They complain that there's not enough aides, and so this is why she's not getting a lot of things done.[1] The different aides and the administrator complain. She complains about the aides not getting things done that she, you know, she says, "You know how the help situation is. You just can't get them." But I know she let some awful good help go. Yes, she's had some good help there that she's let go.

So my cousin is incontinent because she has no way of asking. If they would come and take care of her she has plenty of good control of her bladder.[6] Her skin is in good shape. She's not incontinent that much, because I go.[9] But the thing is, you pay them to take care. Why should I have to take care of her eyes and take care of her teeth and take her to the bathroom and exercise her and walk her and all this? A person pays for it, and they don't get what they pay for,[6] and they raise the rent on top of that.

RE: Nursing Home #37 SC

Number of homes in this town: two

DORA: I go over there regular to #37 to see my aunt. And my friend Mary's grandmother is there, too, and has certainly gone down hill. And in my opinion, it is just the care that nobody is getting. Her grandmother is just a few doors down from my aunt and I've heard that lady sit there and call, "Please put me on the bedpan. I need to use the bathroom. I'll use the bedpan, just come help me, help me."[6]

If it wasn't illegal it would almost be helpful to tape it and send it to Washington and let them hear how them old people have to cry out for help. It's sickening.

My aunt is completely paralyzed and cannot even turn on the call light. She just has to lay there. Anymore, though, she gets where she will holler for help. It's sickening the way they ignore them. I've taken the training and worked in two nursing homes. They are all bad, no matter where you are. They have learned at #37 that I will go by and I will stop and see her.

Going to the nurses' station—you might as well go out and bash your head against the wall as stop at the nurses' station.[8] You've got to go to the top dog and you've got to raise Cain. Then, if you don't get it done you go to Topeka and you really raise Cain.

I have a number that I got back from Senator Dole's office. I probably call over there three times a year. And they jack 'em around over at #37 and then my aunt's took care of pretty good. I'm about ready to jack 'em around again.

I tell you, them care homes are really a sore spot with me. I've done private duty for people and they get lousy service, too. The rich are just as badly neglected as the poor. I think the aides need to be paid on a higher scale, because they just drag them in off the streets. I think there ought to be a law against it. And they don't get enough training. Then, when they learn the patients, they aren't making enough money, so they just sort of go down by the wayside and quit.

They're dealing with people's lives. Maybe a lot of them people don't know what time of day it is but they are human. They need to be took care of. And they need to be respected.

Mary Lou did not know who regulates Kansas nursing homes.

MARY LOU: My grandmother entered #37 in 1983. She is 92. She went from the hospital, and it was unbelievable how much less care she got, comparing the hospital to the nursing home. It was just like walking into a different world as far as care was concerned. She was there for her three month period that she was allowed. I took her out and tried to take care of her myself for a month, but that didn't work at all. So I did put her back in the nursing home. She's been there since January 1984.

You know the biggest thing that I noticed is I feel like they're understaffed.[1] They say they're not, but I feel like they are. The patients' bottoms are not taken care of in the manner that they should be.[6] They only get two baths a week, which I do not think is adequate, especially for someone incontinent. That is my biggest complaint.

Another thing that they need, I think, all nursing homes should have lockers. I took her two gowns last week, nice heavy nightgowns. Well, one of them disappeared before it was even worn. The girls did get busy and chase down one of her sweaters that disappeared. It was returned after two or three months. I feel that someone must have taken the gown. So they should, I feel, have lockers. Something where they could lock their things up. Then if something disappeared it would be on the nurses' and staff's shoulders. They would definitely have to take responsibility for it. I think that the help that they have are loving and concerned. I don't think they have enough time.[1] I have heard that when anybody reached the level to get a raise, they're just let go. I don't know if that's true. As far as I'm concerned it's just a rumor.

My grandmother is incontinent, and she can't walk. She'd had several strokes, but that didn't seem to affect her as she just got to where she couldn't walk anymore. Then at night, she has to be checked every hour or so all night long. It wasn't anything I could do anymore without help. I didn't sleep for a month.

There is a lot of turnover. Girls last maybe three or four months, most of them. Some of them have been there longer. I thnk it's minimum wage they pay. I get $5.50 an hour for babysitting! So that isn't good wages for this area.

They give them big breakfasts. There's bacon and there's eggs and there's cereal. They do give them good breakfasts.

I was getting a girl to help me help my grandmother get in the car, and she said, "Will you show me what to do?" And I said, "Oh, you don't know?" And she said, "No, this

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is my first day here." I think they hire people and then train them on the job.

They are definitely understaffed.[1] Some of the people there need just as much care as patients in the hospital. They just simply don't get it.[5] I didn't blame the girls because I know they were busy, but I've gone up and found my grandmother wet and of course she does have a problem, and it could have been that she had been checked recently, but I know that I will see the girls just rushing around and putting maybe ten or twenty patients to bed.

Most of the people up there are in wheelchairs. One of the things they do is have a lot of entertainment, and they're big on holidays, which, you know, most of the patients do appreciate.

This is something else that comes to my mind. It is hard when you go up there to *find* anyone. Sometimes there's no one at the desk. Nobody's out there working.[6] Now, on one occasion they were all in the lounge.[7] Now, I know that I expressed my disapproval, you know, as kindly as I could and I've never found that to happen again.

They get my grandmother up about seven. I go up there every morning while she's at breakfast and that's usually from about seven-thirty to eight-thirty, somewhere along in there. And then I go up in the evening then. Very seldom do I ever miss going up in the morning *and* in the evening.

RE: Nursing Home #38 SC

Number of nursing homes in this town: one

Martha did not know who regulates Kansas nursing homes.

MARTHA: I recently spent 5 days and 5 nights caring for my grandmother in a care home. She had made the decision to go, as she is bedfast and needs 24 hour nursing care.

She was given a room with another little lady and her new "home" was one hospital bed, one dresser, one night stand, and a closet. The room measured 10 by 10 at the most. The odor of urine met us at the front door and worsened as we went down the hall to her "home."[5]

I can't tell in words the degree of noise created in the halls and utility rooms. I am sure the walls are of paper.

The two employees responsible for 56 patients during the night would turn their radio on so it could be heard throughout the building.[5]

One aide asked me to help read my grandmother's chart.[7] I didn't know how either!

The public rest room was just as I said, "public." It was used by the public, the patients and the employees.

In five days that my grandmother spent there, I was in and out through the day and had to clean her bed and gown three times during that time.[6]

She had a stroke, has to be fed, can't move, has no control, but her mind is fair. I took care of her as long as I could and then I just couldn't handle her.

I didn't think they had enough nurse's aides[1] and I didn't feel like it was clean. The building is old, and I know you can't build a new building every year, but it just needs some work, really. The room my grandmother had was maybe 8 by 10 or 10 by 10. I don't think it was that big, but there were two patients in it and no bathroom. There's only one or two bathrooms on that wing. They built on within the last few years, and that part of it isn't nearly as bad as the old part.

It was at night time the help was really bad. Not enough help.[1]

I was in and out about three times a day, and then I stayed at night. I'm not sure I should have. I did see an awful lot that maybe I shouldn't have seen, you know, because that's putting those people on the spot. I get upset, but I think maybe I'm the one that's thinking wrong. It's messing up people's lives.

I felt like the medication was watched pretty good, but I didn't feel like she was kept clean and dry.[6] One time I went in right after a meal and she had tried to feed herself and spilled it all over. And so I waited a little while, but then, finally I said to the girl, "Maybe I could help change my grandmother," and she said, "Well, just a minute, we have to take all these people back. We told her she would have to wait."[7]

After five days we made the decision to move her to another home. The administrator had asked us to tell her when and if we were not happy or things weren't quite as we had expected. But we felt at that time the blame could be ours, in not being able to adjust to their way of doing things, that our grandmother needed more concentrated care than she was getting.

And I did tell the administrator because she had asked me to, but not until the day we left. And she said, "I wish you'd told me." And then I said, "We tried to adjust to your way of doing things and we couldn't." And that's the truth. Because maybe there is no other way. I didn't know. Even if my grandmother could have adjusted, I don't think I could, because it was *bad*.[5] I thought the administrator was trying. I just thought she had such humongous problems. And she still is there and still working at it, so things could be better now.

As I think back: this is home to 56 patients, human beings. Is this the best we can do for them? Do the words "APPROVED BY THE STATE" not have any meaning at all, especially at this particular facility?

The home, Nursing Home Q, we have chosen for our grandmother, is "squeaky clean", fewer patients per aides or LPNs, better food, noise cut down to nil in the patients' area, bed patients are close to the nurses' station, etc. etc. etc.

RE: Nursing Home #39 SC

Number of nursing homes in this town: two

Gertrude did not know who regulates Kansas nursing homes.

GERTRUDE: My father has been at #39 for 2 years. He has something close to Alzheimer's. They called it senile dementia. He does recognize me, but he isn't able to walk by himself. He loses his balance. So he can't walk alone. He had done lots of walking before, but it seemed like all of a sudden he got so he seemed real sick and he just couldn't. He is only seventy-two.

Generally the care is pretty good. One objection I have is they are so often short of help.[1] And I guess that is true everywhere.

One thing I was very concerned about was the amount of

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pay these girls get. And I have talked to the administrator out here and told her my feelings. They start them at $3.60 an hour, and she says, "We evaluate them and upgrade their salary." Well, I know one young lady who has worked a year and is now getting $3.75. And I think she is pretty good. She is real young, but she seems to be pretty good. Some of them, well, you know, for practically minimum they can't get the best of help.

The administrator is Rachel Jones. She has been there at least 10 years. She was there long before Mr. Miller bought the home. Well, one thing I object seriously about, just a couple of months ago they started adding more to the cost per patient. Everything you have done has points and they charge you for it. Like, if you are incontinent, or have to be fed, or have to be helped from your chair to the bed, or have to be dressed. Right now they add about $90 a month for what they call ADL,—"act of daily living." Right now, my father is able to feed himself. If he couldn't feed himself it would be more. It's 60 cents a day for each point you get and certain things give you two points and some three. I wrote to the owner, Mr. Miller, at the time we got the letter and told him I thought since he was doing that that he should pass at least part of the increase along to the girls who did the work. He, in the meantime, raised our basic charge $25 a month.

My dad is private pay, and it's $1100 per month now. It was $1075 before the last raise two months ago. Then you add that $90, and $140 for Attends and $30 for underpads. And those girls doing the work don't get the added money from this "act of daily living".

For awhile he could ask to go to the bathroom. And sometimes I think, well, they had him in one of those pants in case he had an accident, or if they didn't have time, you know how that goes.

Sometimes I find him soiled, but not very often. One day I did, recently, he wasn't even up yet from a nap after 4:30 and he was soiled. I asked somebody and they were short of help—somebody just didn't come in.[1] Or called in at three o'clock.

I usually go every afternoon about four o'clock and the med aide comes down the hall with water and juice or something, but she never offers him any when I'm there.[6] Now, they should all have something, because he is not going to get himself a drink of water. And I don't know why she doesn't give everybody some juice, but she doesn't. She gives juice to those people who have to have medicine, but usually just water.

The food, it varies. Sometimes it is pretty good, and other times not. I think it gets awfully tiresome. They have so much hamburger with kind of a gravy on it. It is more adequate than it was for awhile. Several of us complained. It's better, but one objection I have is they don't feed them anything fresh. Except maybe a little greens and I'm usually not there at noon. Now one night I went in the kitchen for something for somebody. And one fellow won't eat anything except a sandwich and they neglected to give him a sandwich. I went in to get some bread and butter for him. And they had lettuce and tomato there, and I said, "How come they didn't get any on the other side for a month?" They said, "Those people can't eat it." *Some* of them *could* eat it. But they just aren't giving it.[6]

The ones who are getting it can wait on themselves. On the north side they feed those people who have to be fed and those that are on special diets and have to be watched. Now, my dad can eat in a wheelchair with a tray on his chair and he can feed himself and he does very well. Sometimes he will forget and spill his glass of water, but I still say he has his own teeth and he can eat those things.

I haven't complained too much to Ruthie, she's the Head Nurse. She is very good. We do have some real good R.N.s. Ruthie was there late last night because they were short on the three to seven shift.[1] She was there helping.

I think they could plan a menu better. A little more varied. One lady, in her right mind, complains about getting so tired of the same thing. They don't pay any attention. She does not like gravy and she has been there ten years and they still haven't learned that. I have written to the dietician. They do that in the town where the headquarters is. I have never seen the dietician.

RE: Nursing Home #40 SC

Number of nursing homes in this town: three

Kate Wood did not know who regulates Kansas nursing homes.

KATE WOOD: My sister Rita is in #40. I really think the main thing with #40, first of all, they are understaffed.[1] And secondly, I think that the staff they do have was very uncaring. And thirdly, I feel like the lack of communication between the administrator and the personnel was very nil and I really feel like the administrator could have cared less of what went on.[7]

The administrator is Celia Bailey. When we went in and talked with her after Rita entered the hospital, she was very unknowing of just about everything that had happened. She tried to give us the impression that Rita was a very hostile person and they could not keep her restrained in bed and so forth. And she also made the comment with the side rails she was even able to get up out of bed. There was no side rails *ever* put on that bed, even though the doctor demanded and requested that she have side rails on the bed.

When she came up with the broken nose and the gash over her eye and a big bruise the full length of her head, they made the comment that she had fallen out of bed. Everytime she had gotten hurt she had fallen. And the doctor said there was no way possible that she could have fallen out of bed and gotten a broken nose. He said it had to be a direct blow to the nose. Those beds are not hospital beds. They are more the height of a youth bed.

Her roommate also, about two weeks after Rita received this broken nose and gash on her head, her roommate was a very sweet little woman, probably dripping wet she didn't weigh 80 pounds. And two weeks later when I went in to see Rita, her roommate Margaret was sitting in the wheelchair out in the hall with a sling on her arm and her whole face was bruised and she had a gash over her eye and I asked her, "Well, Margaret, what happened to you?" And she says, "They tell me I fell out of bed." I said, "I've heard that story before and I don't buy it."

And I know another thing: I feel like at #40, to help with problems, they keep their patients pretty well doped up. I went in there one time, for instance, my son was home for Christmas, and my daughter and son and I went in and Rita was laying half on the bed and half off, and just as stupid

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as she could be and she had messed herself and it was dried on her legs.[6]

This was like 2 or 3 o'clock, the middle of the afternoon. It was before shift change. So, my son just went to pieces and he went down there and said, "Y[illegible] get in there and clean my aunt up. My aunt don't have [illegible] in that kind of mess." We went in and there was dried mess in the bathroom and this nurse aide that came in, I just stayed in the room to see what would happen and she went to put Rita on the stool and Rita cowered away from her and put both hands up over her head and she says, "No, please don't. Please don't." And I just about come unglued myself.

Another time I went in there Rita was walking around barefooted, no socks, no shoes on. I tried to find some houseslippers or regular shoes and I looked all through the closets and I couldn't find anything and she had two shoe racks of shoes in there at one time. Anyhow, I got down on my knees to look under the bed and there was dried vomit under that bed, so dried that it was cracked, wrinkled up, drawn up on the edges. So I went down and reported that also to the nurses, and they had such an uncaring attitude! My pet name for the place is butcher shop. At the time Rita was entered in the hospital, one of the registered nurses told me, "She is the third patient from #40 and one of them is in intensive care." Just about a week after we took Rita to Nursing Home R, this roommate of Rita's died, Margaret, I mean. I happened to see an RN, I won't repeat any name or who she works for, but I did see an RN from the hospital about two or three weeks ago and she commented on the fact that Margaret died of dehydration and that she had been in a dehydrated state for five days before the people at #40 reported it to the doctor.[3] I know an administrator from a nursing home in another town, and her mother had been in #40 several years ago and they let her die under the same circumstances.

Rita is a partial Medicaid patient. She had two incomes which totalled over seven hundred dollars and of course then we had to get the Medicaid to fill in the rest. Rita also had, they suspected, a brain concussion which happened about six months ago. I know we took her in and had the CAT Scan because they were afraid of a blood clot. She had supposedly fallen and struck the back of her head.

Also on these restraint things they said there was no way they could keep her restrained. I told Celia I didn't buy that story. I said, "There is always ways that you can keep them. It may sound cruel but it is better than letting them get hurt." Celia said, "Well, I even went in and tied her restraints and tied them in knots that I know that most people couldn't get untied." I said, "I wouldn't be bragging about it if I couldn't tie a knot that a little frail woman couldn't untie." She also said they would tie her in those big highback chairs, restrain her in the big highback chairs, and she would just pick them up and walk around. And I said, "Celia, she wasn't able to walk around carrying one of those big highback chairs. I may be dumb but I am not stupid." She says, "Well, that is what happened." I said, "You are not going to convince me that that is what happened because Rita doesn't weigh probably 80 pounds now. She weighed a hundred and forty-five pounds when she went in to #40."

There was another instance that one time we had gotten several complaints from several of the residents that Rita was not eating and she was not being fed. So my husband and I went up three evenings in a row to watch and they did not know we were there and they had not even tried to feed her.[6] So I went up there and started feeding her.[9] And I went up there, feeding her, and that time that I was there, one of the nurses' aides, somebody was needing to be fed, one of the residents said something, and the aide said, "Well, that's tough. If he can't feed himself, he can just go hungry."[8] So I said something to the LPN that was down on the North end at that time. She said, "Mrs. Wood, come here, I want to talk to you." I said, "OK, fine, I want to talk to you, too." She said, "I know why you are here." And I said, "Oh, why am I here?" She said, "I know all these stories you have heard from these residents." And she says, "It is not true." And I said, "About what?" And she says, "About her not getting fed." And I said, "Look, I have been there three nights in a row and there was no attempt whatsoever to feed my sister." And she says, "Well, look, lady, if you think you have any problems here, you come to me first."[8] I said, "Look, lady, I will find out myself first if there are any problems and you better believe you'll hear from me."

I think she was probably the LPN that was the head of the wing at this time, the evening shift, probably 3-11, because she was there during the supper hour. I also told the administrator about that and she, of course, was unaware of it. She was unaware of anything and everything that went on.[5]

I got a phone call on a Thursday morning, two months ago, that my sister needed to have the stitches removed from her forehead. The woman there called and wanted to know if I would like to go with them. And I said, "Where should I meet you?" And she said, "Why don't you meet me in here?" I imagine she was the social services person there. Well, when I met her there, then she was not going. She gave me the impression she was going, and when I got there she decided she wasn't going to go and she made the comment, "Oh, by the way, you may want to have your sister's hip examined by the doctor." I said, "Her hip? Why?" She said, "Well, a night or two ago, two aides were getting her ready for bed and they let her fall." I said, "They *let* her fall?" "Well, yes," she said. "They had gotten her up out of the wheelchair and then she fell."[6] I said, "Well, what were these two nurse aides doing?" She said, "Well, they were trying to get her ready for bed." And I said, "And they let her *fall*." And she said, "Yes." And I said, "Why had this not been reported before?" And she said, "Well, they didn't realize anything was wrong with her hip until they saw the bruises."[7] I said, "The bruises! You know bruises don't happen overnight." And she said, "They noticed whenever they stand her up on her feet, that she would wrench in pain." And I said, "Nothing was done about it?" And she said, "No, we thought we would wait until she went in to get the stitches out of her forehead."[3]

So when we got up there and I told the doctor about it and then he called for an Xray and he said, "Yes, her hip is broken. We are going to take her to the hospital." I called #40 and told them my sister's hip was broken, and we are taking her to the hospital. Celia did not know until I called and told her her hip was broken that anything had been wrong. She was not aware.[5] When my brother and sister-in-law and I went in on Monday after Rita was admitted to the hospital Thursday, she admitted she was unaware anything had happened until I called. I cannot prove it, but from the comment that she made, the accident report was not even

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filled out until that day.

Celia Bailey is no longer the administrator of that home either. I found out from somebody at the grocery store that she is no longer employed as a nursing home administrator. I said, "That is the best news I've heard. I just thank the Lord that she got out." She was out at one of the car dealers. I heard from a reliable source several months before all this happened that when Celia was moved out here, she was under state investigation at that time.

Something else I might mention, too: every time any of these little accidents happened, they were reported to SRS. They would go out and check them out, but there was nothing to be found. And also, this last time, when we called and reported to SRS about Rita's hip being broken they went out immediately to the nursing home, and at that time there was an accident report provided, and they said they had the feeling that that report had just been made up and backdated. But they said their hands were tied; they had gone as far as they could go. Pamela is the head of the adult care services at SRS in this area. I said, "You mean you can't do anything more?" She said, "No." I said, "I don't know about you, but I am so frustrated, I don't know which way to turn." She said she wished there was more they could do. I said, "I do, too. It looks like to me with all the reports that were turned in that they could follow up on it." And she said that their hands were tied. I said that I realized that my sister's condition had gotten so bad that there wasn't much they could do for her, but I certainly hoped that something would come out of this that somebody else could be saved.

So Rita is now at Nursing Home R, and getting much better care. She is able to be up in the wheelchair now, and the other day they said they put her in the wheelchair, and by the time they got back to the nurses' station that she had wheeled herself up to the door. And so they went out and got her and wheeled her up to the nurses' station and she just laughs and talks to them. They can't understand what she is saying, but she just laughed and was enjoying herself so much.

She is under no medication whatsoever, only if she has some pain they give her extra strength Tylenol. She is not restrained at all now. They had one of those leg splints on her to keep her leg straight, but they have taken that off of her now. I'm real thankful that we got her into Nursing Home R. If she could have had that kind of tender loving care at #40 that she had there at Nursing Home R, my sister, I *know*, would not be in the condition that she is in today.

RE: Nursing Home #41 SW

Number of nursing homes in this town: one

Nancy did not know who regulates Kansas nursing homes.

NANCY: I put my sister, Alta, in #41 six months ago. She was pretty bad off. She couldn't talk and she didn't walk. It was hardening of the arteries. She just generally got worse. I was taking care of her at home. She's been this way probably the last three or four years. Her mind is not clear. She's a "total care" patient.

Seems like I'm always giving the home a bad time, because they don't take her to any of the activities or any of this type of thing. They are doing better now than what they did. They're real short-handed.[1] To me, for the help that they've got, she's had pretty good care, but they've got like two girls to work the one ward.

There was probably between twenty and thirty on this one ward.

She's in a wheelchair. That's something else I was real surprised at. I thought that this was included in the care, the wheelchair. But you pay extra. You pay extra for every little thing. She's a private pay patient. I have to pay fifteen dollars a month for one wheelchair. If we don't pay extra for the bed and the laundry we really shouldn't pay extra for that wheelchair either.

I think they're short-handed because the pay is not good enough. And then the work *is* hard. To me they should have a man helping these girls lift on these people, but they've got these small girls. It's just really pretty hard. I've seen lifts used on some of the heavier patients.

And then like walking Alta. We walked her some at home. They weren't doing this until I threw such a fit. They're *supposedly* doing this. They tell me they'll do these things, and they're real good at doing it for awhile until I'm kind of not watching them, and then they kind of go back to their old way.[7]

And the ones with nobody to see them—it just really breaks my heart to see how some of these people are treated out there. This one guy came up to me and he wanted to know if I had something to eat. And I said, "No, I don't have anything for you. I'll go to the kitchen and get something." So I went to the kitchen and they said he was on a certain calorie diet and he couldn't have anything else. So I didn't say anymore. Then there was a girl that came in one time, I was sitting there and she says, "I'm hungry. Do you have something I could eat?" And I said, "I don't have anything." And I ended up buying her a candy bar. Now, whether she had enough to eat,—I don't know what the score was.

One big problem: I think they're understaffed.[1] You get a few of those aides that really care about these patients, but I'd say ninety percent of them, it's more for a paycheck than it is for the care.

The only ones I've really complained to are the Administrator and the Head Nurse there. And I did complain to both of them, and they semed to want to do what I wanted them to do. But I feel like when I'm not watching that they sometimes don't do this. I just feel like they don't always see it through. I don't think they watch their help that close. They tell them to do something, and they do it for awhile. But then they continue doing it like they want to do it.[7]

The only time I really go out there is of an evening, and I've seen the Head Nurse several times. They're, you know, having problems, and she's with a patient.

Alta can't feed herself. I feed her. Every evening I go out and feed her.[9] She supposedly goes to the dining room for breakfast and lunch. As I say, I've never been out there during that time, so I don't know. I do complain about the food every once in a while. It seems like for awhile you couldn't complain about the food. You couldn't have a gripe at all about their food, and then they'll have maybe three or four nights that they don't give them very much or it's kind of, yuck! Like, when she's had burned cookies, and I just don't feed that kind of stuff to her. We usually take her out something, and if the meal is not good then I'll go get her a malt or something.

Her food is pureed, so I really don't know what the meal

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is. She has green beans and applesauce, it seems like every night. Very, very often. Some nights she might have two, three dishes, and other nights she might have as many as five dishes.

Her doctor went out and gave her a physical when she first came, and I don't know if he was there when she got her flu shot or not. I don't know if he's ever been there since. They tell me that they're supposed to have a doctor out there once a month. As I say, I don't know whether he has been or not.

When she first went out there they did nothing with her therapy at all, and her feet were swelling, and one of the aides told me that she should be up on her feet more, and that would help the swelling. I started walking her down the hall about every evening. I've seen the administrator, and I asked her, and she said, "Well, we'll see about this." And as far as I know she has had this walking about every day now.

She is incontinent. I've not gone out there too often that she's really been wet. There was only one time in the six months that she's been there that she was messy. They have tried, but see, they *know* I'm coming.

Someone told me that it used to be six in the morning when they get them up, but now it's five. Because they are taken, most of them, to the dining room. So they are allowing for that extra time. And they take turns. One morning it's one end of the ward. The next morning it's the next end of the ward, so it's not quite so early. The shortage of help is bad.[1] And then sometimes the way they feed. I just get very upset. Some evenings I go out there and she has two things to eat, and sometimes one of them is a third full. But now they have told me, if I don't feel like she's had enough to eat, that I can come to the kitchen and get her more. Which I never have, because I usually get something. We'll go get a malt or give her something.

There's another trouble out there, too. Seems like they've had a lot of people that fell. And they've had several in the hospital. Two broken hips, just in the six months that Alta's been there.[3] There's one woman that broke her head open.

I went out there one day and Alta was sitting on the stool. They do put her on the stool. I looked for an aide, and she was in the TV room where the patients watch TV.[3] Alta was sitting in the restroom all by herself. I think this is bad because they could get up and fall. The woman that broke her head, stitches in her head, my understanding is that she fell in the bathroom. They found her close to the bathroom. And I couldn't tell you about these others that broke their hips.[3] They've had several people get hurt.

I think most of your nursing homes are all alike. This is the trouble. They don't have enough help with the people that they have in there.[1]

RE: Nursing Home #42 SW

Number of nursing homes in this town: one

SUSAN: My aunt Mabel has been in #42 for eight years. Judy Pierce is the administrator and the superintendent of nursing is Alice Johnson. We have gone through three administrators in eight years. Judy's been administrator maybe four or five years.

I think in the last few weeks, maybe the care has improved a little bit. I did talk to, I think it was Mrs. Remington, with the state board, that was out to inspect the nursing home because I was displeased with the care. She was out there for about a week.

There are never enough aides.[1] And this is one thing that we have argued about. Within the last year I've gotten two raises in my room rate, because she is—according to them—maximum care, even though I do her laundry.[9] I go out there and feed her one meal a day.[9] I walk her.[9] I clean her up.[9] And if we are out of town, which we often are, I hire an LPN to come in and do this. I have somebody come in and do her hair every other week. She has a private room, and we are paying fifty-four dollars a day for this private room, and we were raised two dollars a day *twice* between January '84 and January '85. We had an extra raise this year. Usually it's raised two or three dollars in January only. But this year we had an extra raise in, I think it was July or August. It's a lot of money. So I got this raise and I jumped Judy about the care Aunt Mabel was getting and this raise. And I told her that they could not do this. And that I didn't think where I hired somebody to come in and take care of her, and I came out and took care of her, that it was justified. But it didn't do me any good. And we had quite a discussion over people feeding and walking her (which has been a big, big bugaboo). Aunt Mabel fell and broke her hip a year ago due to their neglect.[3] She's eighty-six years old. Physically she's in really good shape. She's just senile. She probably will live another ten years. But mentally she's—you know. They were walking her back from supper and had a Posey around her. And when you put those Poseys around she would pull back and would not walk. And they were walking her back with this Posey on her. They let go to answer the telephone, and where was that woman going to go but backwards? And she cracked her head and broke her hip and skinned up her elbow.[3] It was an aide and she just let go. We pinned the hip, and she walks with aid with a walker; and she does very well if you don't put belts on her (which they demand that you do); and you don't walk her like she was going to a fire; and you don't get her up out of a chair where she has been sitting for two or three hours and just expect her to take off like a teen-ager. You can't get this through their heads. *I* walk her in the room, and stuff, by myself, all the time. You know, I get her off the toilet and walk her to the bed and walk her to her Geri-Chair.[9] I can do this without anything and by myself very easily. I was walking her back and forth to the dining room but I developed serious back trouble. So I don't do that any more. And besides that as long as they insist on putting a belt on her, I will not walk her. They hurt. They don't know how to put them on[7], and they just *pull* her with it[6], and I refuse to even help them with a belt on. And Alice and I have had lots and lots of fights over that.[6] And what really aggravates me is that ninety percent of the patients in similar condition, they don't walk with a belt, but Alice is going to show me that she's got the authority.[8] Anyway, they put those belts on, and they cinch them down until they can't breathe. They catch her breasts in them, and then they just take hold of the back of that belt and *pull* her out of the chair. And they expect her to just take off and walk. And I realize that it's more work to just take her into the dining room and back; but I feel like I'm paying for it, and out of all the patients out there that have fallen and broken their hip, she is the only one still on her feet. And I'm going to *keep* her there if I can. They've had people fall and break arms and hips and stuff, two or three a week.[3]

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I've been writing down when I go out there if she's wet, if she's dirty, if she's sitting in the chair or she's been laying in the bed four or five hours.[6] How many falls, if I hear about it, and I probably will, I'll *document* it.

Aunt Mabel is incontinent only because they won't take her to the bathroom.[6] I mean, yes, she is in diapers, which was another big fight. It's too much work to take her to the bathroom. And they don't have the help.[1] But if you take her to the bathroom every couple of hours, you wouldn't have any problem at all. To me it would be less work.[7]

That's what I would prefer for her, take her to the bathroom, because then you aren't near as apt to run into bedsores, and this they have a lot of! We've been out there eight and a half years approximately, and she's got good skin and good hair. And I, I feel very sorry for people who, if you don't have somebody who comes in and takes care of you, you don't get the care.

I have a girlfriend whose mother is out there, and the other day Clara came out there to see her mother. She sees her twice a day, too. She came out, and they had just brought her mother out of a whirlpool, and her hair was dry, and Clara got to looking at her, and her head was red and scaly and had sores in it, and she said to them, "If you just brought her out of the whirlpool, why didn't you wash her hair?" "Well, they weren't supposed to wash her hair." And she had not had her hair washed for eight or nine weeks![6] And Clara said, "Who said you weren't to wash her hair?" Well, they didn't know! Nobody knew why they had been told that they shouldn't wash Ida's hair, but they just hadn't done it.[7] And her scalp! If Clara hadn't been there and caught it, then, you know, it would have—

They don't have enough aides to get things done[1] and the RNs and the LPNs are not going to go back there and give bedside nursing. It's beyond their dignity!

When Judy and I had our little discussion she informed me that they had to have forty hours of training before they could be put on the floor, because I said the kids didn't know anything. I really didn't blame them. But I blamed her and Alice. She informed me of that law. And I said, "Yes, I was aware of it." But the following Sunday the people in housekeeping were in there feeding![5] And the people from the kitchen, very often when there's no help, feed.[5] Those little girls that clean the table and stuff shouldn't be feeding. And we have another problem here. Most of the aides are student nurses, so in May and August you don't have any help[2], and in January.[1] I mean, these kids, when vacation comes, they all go away. And then, too, I think that a lot of this is that Judy hires these kids that they have to train to get her tax break.

I think there are enough certified aides around, the problem is, when a girl's been there a year or two, they get rid of them. I honestly feel when the girl is trained and on the ball, then they do everything they can to get her to quit. I don't know what the reason is. I know for a fact, one of the CNA's that they had out there had been there, I think, six years, they got rid of. She was a very good nurse's aide. In fact, I hired her when she off duty to take care of Aunt Mabel if I was gone. But they just gave her crappy hours, and they cut her pay and froze it, and just anything and everything constantly. You know, everything was wrong. "You're not doing anything right." And she just told them to take it. And this happens to a lot of them.

Also, Alice told me when I was bitching about those belts, that if I didn't like the service, why didn't I check into moving her someplace else?[8] I told her, I said, "Alice, forget it. I'm paying my bills, and she's no danger to you or any of your nurses, and she's no danger to herself; and as far as I know that's the only three reasons that you can get rid of her." I said, "She's had the very best of care and she's going to get it until the day she dies as long as I'm able to see to it. And I'm not moving her." And I *mean* it. I'm not driving seventy miles a day to take care of her. If Alice doesn't like it, that's tough. I was there longer than she was, and I'll be there when she's gone.

The aides are good in a lot of ways, but they don't use good common sense or good bedside nursing like we were taught to. You know, like before Aunt Mabel broke her hip I walked in one day and this aide was trying to put Aunt Mabel's pants on her. She had her standing in the middle of the room trying to stand on one foot and raise her foot up to put her slacks on.[7] I said, "Sit her down on the bed and put her pants on, and then have her stand up and pull them up. It's simple." And this was when they were bitching about dressing her. Nobody can stand up on one foot at that age and put pants on, I don't care who. The aide said nobody had ever told her to do it that way.

They object to putting her clothes on her now. They want to leave her in bed and change her diaper and put her pants on. That's the way they want to do it because they don't want to have to make her stand up. She doesn't get any water.[6] They can't get her to drink, and they don't ever come in and offer her a glass of water, which she won't drink anyway. She never did like water, and you have to give her fruit juice or put the water in the fruit juice or something like this.

The peri care is very poor as far as I'm concerned. A lot of times I'll go out there and she may be dry, but she'll have dried BM all over her.[6] And they use this spray crap, I don't know what it is, some kind of a peri solution, instead of good old hot water and soap. But I go out, and Laura goes out, and we wash her with soap and water and clean her up and rub her down with olive oil.[9]

They never do anything about oral hygiene.[6] I mean she doesn't have her teeth in any more, because her jaws have shrunk and she can't keep them in. But they can't get her to eat, and they make no effort to get her to drink. This is why I see that somebody is out there to give her one meal a day. Because I figure she's going to be all right with one meal and two or three glasses of fluids. *They* feed her pureed food. *I* feed her anything I can squash up, because she eats better. I don't have too many complaints about the food. The food seems to be pretty good. It's not as good as it *has* been at times. At one time we had a really good dietician. The little girl that's there now turns out fairly decent meals. It smells good, and the few times I've tasted it, it's not bad.

But I have another big complaint. I'm against all the pills that they put down these people. I had quite a big go-round, and we now have Aunt Mabel off of everything. But, you know, the patients open their mouths and get a little loud, and they tranquilize them until they don't know anything.[3]

The last go-round I had with Alice about that was when there was a mild tranquilizer ordered for Aunt Mabel and when I went out of town once time they decided she needed it and they gave it to her, and they damned near killed her![3] They were worried. They called the girl that had been taking care of her and had her come out, because they couldn't get her to wake up. And when I came back I had a few choice words, and I told Alice. She said, "Oh, they didn't do that and they didn't do this." And I said, "Alice, when they called Betty out here to wake her up and

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The Kansas Department of Health and Environment is responsible for nursing home [illegible] take care of her, you *know* they were scared." "Well, the dosage was too big." I said, "I don't care what the dosage was, you are not to give those to her again." "Well, they couldn't discontinue without doctor's orders." And I said, "I can!", and we drove away. And I went to the drugstore and told the druggist that under no circumstances were they to order tranquilizers for her without first consulting me. I've got a big mouth, and I don't mind using it when I'm in the right. She doesn't *need* anything. They give her Milk of Magnesia every other day and that's all she needs unless she gets sick. Which brings up another point.

They leave her in bed for four or five hours, and then get her up and then try to walk her.[8] I think she should be changed in position every two hours. I know several times, I've gone out there at noon or eleven o'clock and fed her and cleaned her up and put her to bed for a nap. And I would go back at five o'clock and that woman is still in bed—had not had *one* thing done to her[6]—and I can document it, because after the last big fight with Judy and Alice when I got that rate raise in August, every day we keep a daily log on what transpires—whether she's wet, whether she's dry, whether she ate good or she walked—everything! I decided that I didn't have anything to prove my point except my word, so I was going to have it in writing. So every day since then, either Laura or I or whoever's taking care of her writes down whether—well, I've got one here. It says, "She was dry. She ate well. She is sleeping. She had red marks on her neck and right arm and back. And she was back from the dining room at twelve-thirty. They took her in there at ten-thirty and she got back at twelve-thirty."

The Kansas Legislature Can Do It! (*if* we ask them to)

continued from page 1

Concerning the forty-two homes discussed in the Special Series, we find comments specifically indicating inadequate care. Some conditions mentioned are: understaffing of aides with inevitable patient neglect, staff arrogance and bullying of patients and of their relatives; and deliberate humiliation of patients.

Why do these conditions exist?

First, we find obvious failure by the state of Kansas to ensure adequate care in all nursing homes. The agency designated by the Kansas Legislature to be responsible for writing and enforcing nursing home regulations is the Kansas Department of Health and Environment (H and E).

Second, we find a lack of needed supervision of the care given to the patients; there should be in each home a sufficient number of licensed nurses to provide this supervision.

Third, we find gross understaffing of aides. This is important because aides provide nearly all the nursing and personal care to the patients.

Fourth, we note that the comments support the opinion that the aides have inadequate training and salaries. Because aides provide so much of the care received by the patients, the patients' very lives depend on the aides.

KINH believes that each of these obstacles to good care could be eliminated by changes in nursing home regulations and legislation, as suggested below.

1) Failure by the state to ensure adequate care in all Kansas nursing homes.

The Legislature could require H & E to inspect every home monthly.
At present, H & E is required to inspect each nursing home annually. Monthly inspections would cost little more than annual inspections and would be far more effective.

2) The existing lack of supervision by licensed nurses.

Mandating a sufficient number of nurses is within the authority of the Legislature.
Under the present legislative program, all Kansas nursing homes will be required to have licensed nurses around the clock by July 1, 1988. But many more licensed nurses than this program mandates would be needed to ensure adequate supervision of nursing care.

3) Gross understaffing of aides.

The Legislature could require an adequate aide to patient ratio in the H & E regulations.
Understaffing of aides inevitably means neglect of patients and consequent abuse. The H & E regulations presently contain an inadequate ratio of aides to patients. Because of this inadequate staffing ratio, H & E is unable to enforce their excellent regulations for nursing care. Many homes simply do not have enough aides to turn bedfast patients every two hours, to exercise patients when it is needed, to offer them water or juice in sufficient quantities, to change incontinent patients' clothing when soiled, or to take patients to the bathroom when they want to go to the bathroom, and not at some set time determined by the staff.

4) Adequate training and salaries for aides.

The Legislature has the authority to mandate 120 hours of nurse's aide training, and a certificate indicating satisfactory completion of the course, as a prerequisite for seeking employment as an aide in a nursing home.

However, the Kansas Legislature approved legislation five years ago which prohibits H & E from requiring the completion of *any* course as a condition for employment as nursing home aide.

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This law could not have been inspired by motives of economy, as the cost of training is no greater before employment than after. Currently training costs are paid sometimes by the aide, sometimes by the nursing home.

A requirement for a certificate in nurse's aide training might help to keep persons with personality problems from seeking employment as aides; for example, drug addicts, alcoholics, sadistic persons, etc., as they are less likely to complete the mandated course of training.

We have lobbied for these improvements and others for ten sessions of the Kansas Legislature. But most voters do not know that the Legislature has the authority to make these important improvements. Voters must communicate their wishes to those who represent them in Topeka. When every member of the Legislature hears from his or her constituents that they want better nursing home care, KINH will have a better chance of attaining our legislative goals.

Legislators often object to suggested improvements on the grounds that they would be too costly. True, some of these suggestions would entail increased costs for salaries (for more nurses and for more aides), but might also substantially decrease nursing home patient hospitalizations. In these Newsletters, we find many references to accidents, falls, head injuries, broken hips, dehydration, infections and urinary problems, many of them calling for patient hospitalizations. Certainly some could be prevented by the suggested improvements.

As for possible increases in costs: do Kansans really want to put economy above the well-being of our relatives and neighbors in nursing homes? Do we want these patients to be told: "Go in your diaper!" by understaffed, underpaid, undertrained, and under-supervised aides? Would we be happy ourselves under these humiliating and uncomfortable conditions?

The Legislature is comprised of conscientious and hardworking human beings whom we have elected to represent our interests. **We must talk to our legislators about nursing home neglect and we must ask the Kansas Medical Society to give us their strongest support.**

It's up to us to ask for better care.

It's up to the Legislature to give us better care.

Violations of the following regulations, excerpted from *Regulations for the Licensure and Operation of Adult Care Homes*, Kansas Department of Health and Environment, May, 1984, are frequently mentioned in many of the consumer interviews found in Volume I, Numbers 1-6.

28-39-86 HEALTH SERVICES.

The skilled nursing home and intermediate nursing care home shall provide organized health services with qualified personnel to meet the health needs of the residents and shall meet the health services requirements prescribed in K.A.R. 28-30-87 to K.A.R. 28-39-92 inclusive.

(Authorized by and implementing K.S.A. 39-932; effective May 1, 1982.)

28-39-87 (c) Staffing.

(5) Personnel shall be immediately accessible to all residents to assure prompt, necessary action in case of injury, illness, fire, or other emergency.

28-39-87 (f) Resident care and hygiene.

The facility shall provide supportive services to maintain the residents' comfort and hygiene as follows:

(1) Residents confined to bed shall receive a complete bath every other day or more often as needed.

(2) Incontinent residents shall be checked at least every two hours and shall be given partial baths and clean linens promptly when the bed or clothing is soiled.

(3) Pads shall be used to keep the resident dry and comfortable.

(6) There shall be available fresh water for all residents. For all non-ambulatory residents, fresh water or other fluids shall be available at the bedside at all times unless fluids are restricted by physician's order.

(7) Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be taken to prevent dry, cracked lips.

28-39-87 (h) Supervision of resident nutrition.

(1) Nursing personnel shall monitor food and fluid intake of residents and shall assist, when necessary, in the feeding of residents.

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The Kansas Department of Health and Environment is responsible for nursing home

KINH News

KANSANS FOR IMPROVEMENT OF NURSING HOMES, INC.
913 Tennessee, No. 2 • Lawrence, Kansas 66044 • (913) 842-3088

SPECIAL SERIES
Vol. II, No. 1 May 1986
Petey Cerf, Editor

About Volume II of the KINH Special Series

In this first issue, #1 of Volume II, we present: (a) excerpts taken from the official transcript of an administrative appeal hearing *Before the Kansas Department of Health and Environment in the matter of U.S. Care Corporation and Kansas Health Care Systems Limited Partnership, d/b/a Wichita Care Center, 1319 West May, Wichita, Kansas, 67213,* on December 17, 1985; (b) the *Initial Order of the Presiding Officer*, Jim Parrish, dated February 26, 1986; and (c) *the Notice of Review of Initial Order*, dated March 10, 1986, by Barbara Sabol, Secretary of the Department of Health and Environment. All three are public documents and appear in the order named.

At the time of writing, the final decision of the Department about whether or not to issue a new license to Wichita Care Center has not yet been made. Secretary Sabol has until April 30, 1986, to make this decision. The Department is not bound by the "Initial Order" of the Presiding Officer, but has the authority to decide the issue independently.

Concerning the excerpts from the transcript, because it is a public document there is no need to use pseudonyms. The complainant referred to is the Department of Health and Environment, represented by Mr. Layman, and the respondent is U.S. Care Corporation and Kansas Health Care Systems Limited Partnership, Wichita Care Center.

As has been the practice in Volume I of the Special Series, we continue to assign each nursing home mentioned a number. The last nursing home mentioned in Volume I, #6, is nursing home #42; therefore we assign #43 to the Wichita Care Center.

The next issue, Volume II, #2, will return to the usual form: comments by relatives of patients in nursing homes throughout the state on the quality of care provided to them. —Petey Cerf

Excerpted from the OFFICIAL TRANSCRIPT

BEFORE THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

In the Matter of U.S. Care)
Corporation and Kansas Health)
Care Systems Limited Partnership,) No. 85-H-99
d/b/a Wichita Care Center, 1319)
West May, Wichita, Kansas, 67213.)

Proceedings held in Room 531N, Kansas State Capitol Building, in the City of Topeka, County of Shawnee, State of Kansas, on the 17th day of December, 1985, beginning at 9:00 a.m., before Mr. James W. Parrish, Hearing Officer.

Appearances

The Complainant appeared by and through its counsel, Mr. Frank W. Layman, Attorney, Kansas Department of Health and Environment, Building 728, Forbes Field, Topeka, Kansas, 66621.

The Respondent appeared by and through its counsel, Scott, Quinlan & Hecht, 3301 Van Buren Street, Topeka, Kansas, 66611, by Mr. Jack A. Quinlan.

HEARING OFFICER PARRISH: We're ready to reconvene in the matter of the U.S. Care Corporation, Kansas Health Care Systems, Limited, doing business as Wichita Care Center, and I will yield to Mr. Layman, who is examining the current witness.

[Editor's Note: The "current witness" to whom Mr. Parrish refers is Sue Robbins, R.N., a state surveyor for the Department of Health and Environment.]

Q. (BY MR. LAYMAN) Okay. Ms. Robbins, based upon your observations and utilizing your professional judgment and experience, could you describe the conditions of the residents and the care they were receiving at the Wichita Care Home at the time of your inspection on October of 1985?

A. As we made the tour of this particular facility, especially on—I'm speaking at this point as we made the tour on C wing, which is the skilled wing—there was one registered nurse who was in charge of that wing, there was a registered nurse who was giving nursing care and also a nurse aide to take care of 24 residents. As we made the tour, I noticed that the nurse giving medications had left medication at the table for a patient with multiple sclerosis to self-administer. Later on, there were no orders for that medication to be self-administered. There was a lady that had a nasal gastric tube feeding, which is a tube that goes down the nose into the stomach to provide nutrition. The particular orders for this resident was to receive instant breakfast on a 24-hour basis, which was like a half a gallon, which would be a pitcher full. There was a half a pitcher in this particular refrigerator at this nurses' station, and a new pitcher was brought up at ten o'clock, which would be for the next 24 hours. When I looked at the documentation on the record, they had already documented the tube feeding had been done at ten o'clock and at twelve o'clock. However, there was still a half a pitcher of solution left from the previous 24 hours. This particular lady is debilitated. She is bedfast, she does have a bed sore. She is in a contracted position. She needs turning frequently. She also has both wrists restrained to keep her from pulling out the nasal tube and also a Foley catheter, which is for the urine collection. When I was reviewing the particular resident for a skin assessment, both wrists were restrained. She had pulled on the restraints so tight that the particular area of her wrist was devoid of skin; it had pulled the skin loose because she had pulled so much on the restraints. When—this lady is also in what you call a fetal position. She cannot be stretched out and has to be turned bodily from one side to the other.

Going on further down the hall, there was a lady that needs help with feeding. She had a puree diet, which is one that has all of her food ground up. She was lying to the side of her bed over to the side, trying to get her breakfast to her mouth. Her tray was probably three feet away from her and she was trying to drag the breakfast across in front of her, spilling most of it before she got it. There was another lady that was flat on her back in bed. The breakfast tray was at the end of her bed. It was cold, and there was nobody in there to assist her with feeding.

Later on at the noon meal, in reference to feeding on this particular day, there is a 38-year-old woman who has had a stroke. She was paralyzed on her right side in a wheelchair. She was sitting back away from the lunch table. Her tray was here (indicating). No one had bothered to cut up her meat. No one had provided her with utensils to eat with. She did have a fork in her left hand trying to eat stewed tomatoes from a distance of four to five feet, trying to drag the stewed tomatoes across in front of her. When looking at her care plan, it did state on the dietary assessment that she was unable to eat by herself and needed the food chopped and somebody needed to assist her. The food was not chopped and no one was there to assist her. Another lady in this particular time at this noon meal, there was residents in the C wing dining room, there was no nursing staff in attendance. One lady was eating with her hands. Another one had already taken a tray from another resident, had pulled it over in front of her and was commencing to eat. There were three residents in this particular wing that were restrained without physician orders. One in particular was a bedfast lady who also had a nasal gastric tube feeding. She had both wrists restrained and in addition she had a vest restraint and she was restrained in bed, restricting her movement from side to side. Another gentleman had no orders for a vest restraint that was observed being used in bed. Another lady that wanders frequently throughout the facility had been restrained in the geri-chair at the nurses' station, apparently for the nurses to observe. However, she had no order and there was a specific order on her chart that she was not to be restrained. The residents that were bed bound, that needed to be turned from side to side, the ones that had skin problems were found to be left in the same position for two and a half hours and not turned. One of these in particular did have a bed sore or decubiti. And the reasoning behind turning them from side to side is to increase circulation so that that particular bed sore could be nourished and the blood supply replaced. There were male residents in wheelchairs that had pelvic restraints that were uncovered. One gentleman in particular, his knees were raised enough out of the wheelchair with the pelvic restraint that it was clearly cutting into the side of his leg. This was evident throughout the three residents that we observed with pelvic restraints. Residents with problems on their heels in bed, like with one lady in particular had a decubitus on her heel or a bed sore. It was a large area about an inch and a half to two inches of a scabbed—black scabbed area. There were specifically orders on her chart for a heel protector. These were not in use. I found residents that were wearing what we call Attends or it's like a Pamper, a geriatric diaper. They had been in the Attends long enough that they were urine soaked. The urine had soaked through to the incontinent pad on the bed and the urine was dried. It had a brown stain around this much (indicating) on the incontinent pad below the Attends. There were two residents I found. One of those particular residents was also a debilitated resident with a nasal gastric tube feeding. I had one resident that had a Foley catheter for urine. It had been pulled out on October the 13th at two o'clock in the morning. No one had bothered to replace this particular catheter because they had no catheters in stock. Two days later apparently it was replaced. This lady was also the one that was found in the diaper, saturated with urine and the brown urine stains underneath.

This particular time, most of the care plans were still being revised and many of them had the long-term, short-term goals missing and many of the problems identified. Staff was unaware when we asked where the care plans were, and these are to be provided to the staff to provide care, to understand. There's a lot of new staff people that work there, and this is what they would use to understand how to take care of these particular residents.

There were medications that were not given because the medication was not available. There was one lady with a nasal gastric tube feeding, did not have a medication given because the medication nurse couldn't find the medication. The storage of medications, again, was—there was stool softener in a medication cart. The stool softener tablets that had been removed from the original container were in a medicine cup on the top drawer of the medication cupboard with no identification. There were some Valium injectables that were outdated on the C wing medication room. This was outdated in July of '85. The contents of the emergency medication kit—when I walked into the C wing medication room, there was an emergency medication kit lying on the cupboard. When I looked at the contents of this box, it did not agree with what was posted on top. Then when I opened up the cupboard in the same room, there was another emergency medication kit. No one knew the confusion was between the two emergency medication kits. Neither kit was locked. There were two ampules of Dilantin medication that were in a brown paper sack. It had handwritten instructions from the pharmacist that the consulting pharmacist was to replace this into—to place this into the emergency medication kit. The director of nursing at that time did notify the consultant pharmacist and brought out another emergency medication kit. However, that was not the right kit for the facility. When I was discussing this with the pharmacist, he stated that one of the kits that I found in the C wing medication room had been a lost kit that they hadn't been able to find since July, and suddenly it had resurfaced.

As far as the dietary department, there was one puree diet that I observed that did not receive the bacon or the bread as the menu stated. Food was left to sit out for up to 45 minutes before it was served at breakfast, and they do not have any particular serving utensils that they have a way to keep this food warm. So it's left to sit in these dishes up to 45 minutes before served. The residents at the same table, there would be maybe four to six residents, depending on the size of the table. One resident would be fed; however, the others would have to wait for periods up to 30 minutes before they would be served. Residents' food would not be cut up. There were feeding syringes that I observed being stored at the bedside. These feeding syringes are plastic syringes with a ball on the end of them that they utilized to help feed liquids, water, fluids, et cetera. They were at the bedside in plastic bags, closed plastic bags with moisture on the inside. They were not dated as to when they were placed at this particular position, therefore allowing the possibility of bacteria to grow and causing problems with the already debilitated state of these particular residents. At the B lounge, the long hallway that goes into the B dining room, there was a group of 14 residents in the evening that were sitting lined up along this hallway, and there was an aide that was going around going from one patient to the next clipping their fingernails. There was no sanitizing done between the use these nail clippers. She just went down the line.

This was in general what I found on my tour at this particular time of the revisit that reflected nursing care. And in my professional judgment and my opinion, these residents were not being taken care of.

Q. (BY MR. LAYMAN) Would you say then that most, all or some of the residents that you observed during that tour were receiving less than adequate care?

A. Most.

Q. I'd like to ask you the same question, but base it upon the August, '85—again, I'll restate the question, based upon your observations and utilizing your professional experience and judgment, would you describe the conditions of the residents and the care they were receiving on the August of '85 survey?

A. Okay. At this particular time, when we went in to do the survey, there were two residents that had staph infections. This partcular type of infection was in their decubiti and their bed sores. This type of staph infection is complicated by lack of cleanliness. It is an infection that causes drainage, pustules. They had two of them in strict isolation because of this type of drainage. These particular rooms were private rooms. What we saw were the aides putting on gowns that were short-sleeved. In essence, their arms were exposed, the aides' arms were exposed from here to here (indicating), thus providing care to these residents contaminating their arms, only washing their hands and then moving on to another resident to provide care again, thus contaminating or bringing that particular staph germ to other residents in the facility.

MR. QUINLAN: I'm going to object to that unless they did actually bring contamination to other residents. She can testify to that.

HEARING OFFICER PARRISH: Do you know whether there was a transfer of any contaminating bacteria or germs as a result of that?

MS. ROBBINS: That's something I could not prove, but in strict isolation precautions—

MR. QUINLAN: Then I'm going to object to it.

HEARING OFFICER PARRISH: Well, we'll note the objection. You may go ahead and complete that answer.

A. In the strict isolation procedures, you are to gown and glove, wear a mask to go into this room. Hands are washed before you come out. There is to be no part of you that will be contaminated that can carry on to another patient. That is the object of strict isolation. There was one particular lady that was contractured, had contractured hands. Both hands were tightly closed. She had orders on her chart for cones to be provided to keep the hands open. Those were not provided. The residents' beds had been padded with numerous layers of material. You would start with like a draw sheet, then there would be a sheepskin over the top, then there's an incontinent pad on top of that. Then the patient would also be wearing the incontinent briefs or the diapers, thus allowing convenience of nursing to pull one layer out at a time so that bed would not have to be changed. The object of the sheepskin is to be next to the skin to provide comfort, and this was not—this was not evident. There were three—

MR. QUINLAN: Do you know from your experience from what you observed that these pads were in fact pulled out instead of changed the way they should have been or are you assuming that?

MS. ROBBINS: When questioning the aides, this is what they would tell you. As they're wet, with one layer, that can be pulled out. Then another incontinent pad can be placed on. There were two residents that I observed in the same position for two and a half to three hours. Both of these residents did have decubiti. Both of them are debilitated residents in contractured positions. There was one resident that had orders to be up in the chair for meals, and he did not get out of bed the entire—on all days of the survey. There was a lack of consistent documentation as to the skin on the charts, as to the skin problems. And due to staff turnover, it would be difficut for a professional person to ascertain from this chart what the condition of this resident's skin is in order to provide care or what improvement had been made or if the treatment was—a treatment of choice, if the physician should have to be notified. There were three residents that I observed on C wing that were totally confused and the breakfast trays had been left sitting at the bedside without assistance. Water glasses were not provided for those residents confined to bed in order for them to drink.

I had treatments that were documented as not given because the medication was not available or because the resident was up in a chair or because the resident had been incontinent and they didn't have time to change them. So therefore, the treatment that was to be given to the decubiti would not be given. Both of the particular residents I'm speaking to had staph infections, one in particular had a Garamycin ointment ordered three times a day. That's an antibiotic ointment that will fight infections. The bony prominences of these particular residents that are in a debilitated state were not protected, and what I'm really speaking to is as they're laying on their side, there was nothing between the legs to keep the knees from going into the thigh or the ankles from rubbing on the side of the sheet. There needs to be a padding between these two areas to protect them so the pressure areas would not develop. There were also medications ordered for the two residents that had the staph infections. One of them was not started for a day and a half until the medication came in. However, this particular medication was available on the emergency medication kit and could have been started immediately. Storage of medications, again there were medications that were stored in the C wing medication room from residents that had expired three months previous. There was a large sack of medications stored in the cupboard containing like potassium chloride, cream, Compazine. There was some Proderm, which is a spray for decubiti. There was also outdated medications for administration. There was, again, some Valium that had been outdated since June 1st of '85. On this particular visit, too, the keys to the medication room were left at the C wing nurses' station, accessible to anybody that would walk by and want to get in this particular medication room. The medication kit, too, again, was stored on the B wing nursing station instead of C as their policy had stated, and it did not contain the current approved medications. Dietary, again the diets were not served as posted. They didn't have any planned menus for particular 1600 calorie and 3000 calorie diets. The puree diets were served right—they weren't served regular diets. In other words, the way the menu called for is they would puree what the regular—what would appear on that particular menu.

MR. QUINLAN: I'm going to object to this line of testimony unless she starts telling us who she's talking about. When she says they, they, they, that leaves the impression that everyone there. I think that's not quite fair. I think she's going to have to tell us how many.

HEARING OFFICER PARRISH: I'll sustain that objection. If you could, be more specific with respect to your references and descriptions, and in instances where things are occurring, you can say specifically, you can describe those specifically. And instances where you assume things might happen, be sure and describe that those are assumptions, and if they merit an objection, counsel will object.

MS. ROBBINS: Okay. I will refer back if I can get to my dietary notes.

MR. QUINLAN: For example, I don't know how many residents were to be on a puree food diet, to start with.

MS. ROBBINS: I would like to clarify. I cannot look at all puree diets at any given time. What I will pick is maybe four to five residents and observe what those particular residents have received on their diet.

MR. QUINLAN: So we're talking about four or five, that's what I want to know.

MS. ROBBINS: Okay. On this particular time, I'm talking about diets that I observed were four.

MR. QUINLAN: Were four, okay.

MS. ROBBINS: And three of those four were pureed.

MR. QUINLAN: So you observed four records having to do with diet for four residents?

MS. ROBBINS. Not records. What I was observing was what they were actually served.

MR. QUINLAN: So you observed four?

MS. ROBBINS: Right.

MR. QUINLAN: That's what I wanted to know.

MS. ROBBINS: Of those four, also there were three of those—three of those four also had diabetic diets.

MR. QUINLAN: Okay.

MS. ROBBINS: So in addition to puree and diabetic, I was looking at both aspects in that.

MR. QUINLAN: Okay.

A. Also one of these particular residents that I did observe had orders for three gram sodium, but he was served a pureed regular mechanical, and those orders had not been picked up and taken to nursing. There was also two trays that were deliverd to C wing without identification. These particular trays were for the isolation patients on C wing. They also are the same two people that were served a liquid diet on this particular evening, and the orders were for both of them to have regular or mechanical soft. Again, these were the two residents that had a staph infection, also had decubiti. They really needed adequate nutrition for the healing process. They were served—when I'm saying liquid diets, it was just liquid. It was like Carnation Instant Breakfast. There was a bouillion. Both of those trays were not identified from the point of B wing dining room around to C wing. There was no identification on these trays. They were left to sit at the C wing nurses' station. Again, residents were left sitting at the same table, not being served. Residents were observed in the B wing—this particular time was in the B wing dining room, which is divided into two separate parts. One part is for those residents needing assistance and needing to be fed. The other is for more of the self-fed. Residents would be observed, 25 would sit in this room. There would be one nursing staff available. Residents would be grabbing from other trays, eating this food, pulling the tray over, and with no staff in view or one nurse aide in view, it would be difficult to watch all of them.

HEARING OFFICER PARRISH: For how long a period of time did you observe the residents who were unattended? You said they were sitting unattended. Was that for five minutes or for an hour?

MS. ROBBINS: It would range from 15 minutes to 20 minutes. Then what would happen is as the trays would come out, they would be served to these people and this particular nurse aide or a nurse would then move to another table to assist these. Then these residents sitting over here who did need to be observed or watched to make sure they were eating their food, they could not view.

Q. (BY MR. LAYMAN) Why is it important that they be observed? What's the—

A. The reason for the observation is, number one, to make sure that they do eat—adequately eat what is on their tray. Number two, to make sure that they are served the therapeutic. If the physician orders a therapeutic diet, there's a reason for it. He wants that diet to be served. If they don't watch to to see that they take this, then another resident can take off the bread, another resident can take off the cake and then that resident has not received the diet as the physician has ordered. It's also important in the nursing home, these people are already debilitated. They're here for a reason. They need adequate nutrition, number one, to adequately hydrate them. If they have bed sores, they need the hydration and they need the nutrition for the healing process. That's really some of the things that I did see on the tour on that particular survey.

Q. (BY MR. LAYMAN): Again, how would you characterize this? Would you say most, all or some of the residents that you observed during the August, '85, resurvey were receiving adequate care? All, some or most of the residents were receiving adequate care?

A. They were not receiving adequate care.

Q. Would that be all or some or most?

A. Most were not receiving adequate care.

Q. Okay. And then one more time, we'll look at the May 28th—May 20 visit. Okay. We'll look at the May 20 visit. Again, based upon your observations, utilizing your professional experience and your judgment, would you describe the conditions of the residents and care they were receiving at Wichita Care Center on your survey of the May 20th date?

A. Again, this was an area that residents that we observed were not being released from restraints every two hours as policy stated. There was one resident that we observed in a restraint in a wheelchair that was wet for three hours. This particular visit, too, the acting director of nursing was not an employee of the facility. They were in the interim period at this time with directors of nursing. Health services, again incontinent residents were not being checked and cleaned. We observed residents with food and dry liquid spills on the clothing.

MR. QUINLAN: Just a minute. I've got to object to this. The answer is not being responsive unless she can tell us how many residents you observed in these conditons. I want to know the numbers.

HEARING OFFICER PARRISH: Try to be as specific as you can in describing what you observed.

MR. QUINLAN: How many incontinent residents did you watch, for example?

MS. ROBBINS: This is where I need to check with my notes. On this particular visit I have notes in my briefcase.

MR. QUINLAN: Go get them.

MS. ROBBINS: Thank you. That's at the May 20 visit? This particular visit—I'll have to get my residents straight. I had one particular resident that had been a head injury, and he needed also the cones to his hand because of the contractures, and this was not being provided. The same resident that has a nasal gastric tube feeding, also the decubiti, was still in the facility. She had the feeder syringe in her drawer, also in a plastic bag. There was no date. There was a liquid in the tip and moisture.

MR. QUINLAN: I don't mean to interrupt you. I understand you to say the same resident?

MS. ROBBINS: From—

MR. QUINLAN: From October back?

MS. ROBBINS: She has been in the facility all along.

MR. QUINLAN: So she was in in May and she's one of the residents you talked about in October?

A. That has the nasal gastric tube. There were, again, medications available on the dressing cart from residents that were not in the facility, such as the Betadine solution, some Elase ointment. There was a Fleets enema for a person that was opened and the tip was gone. This—also this lady that had the nasal gastric tube feeding, she did not have the head of her bed elevated at this particular time. With the nasal gastric tube that goes down in the stomach, if the head of the bed is not elevated, there is a risk of aspiration as the fluid that you would put into the tube might have a chance to come out. She could aspirate, causing pneumonia. So the head of her bed was elevated. Her catheter tubing bag for the urine was in a way that drained from the bed down this way and then back up, so that the urine could not flow freely down into the catheter bag. There was also another lady with a Foley catheter that had the tubing on the floor and then it came back up and went into the bag. There was no—this particular resident with the nasal gastric tube feeding had had orders for 70 cc's of fluid to be ingested an hour. The sheet that was posted on the door would range—the nurses were fluctuating back from 40 cc to 50 cc to 70 cc, would up it to 80 cc's. Then there was nothing on a record to indicate how much fluid she had obtained. So it would be difficult to ascertain how much fluid this particular woman had ingested from 7:00 in the morning until 11:00 in the morning.

MR. QUINLAN: This lady was debilitated?

A. Right. Again, for the diets that I reviewed, the particular, there were four, and that referred back to diets not—and of those four, I had one, two, three—three of those four were—no, four of four were diabetics and two were puree of those four. And diabetics were served the slice of bread instead of half a slice. Puree diets did not get the banana and the mold. What they were served were peaches.

HEARING OFFICER PARRISH: Would you clarify what you just stated for me.

MS. ROBBINS: The particular—a menu has been planned by the consulting dietician to provide certain food to the individual, and this particular day, the menu stated there was to be a banana and a frosted lime mold. In place of that banana and the frosted lime mold was served just peaches, so they really weren't following the menu.

Q. (BY MR. LAYMAN): What's the importance of following the menu?

Q. (BY MR. QUINLAN): Diabetic.

A. The diabetics, for one, and the reason for the menu is to have adequate ordering for the diet—if they're going to pay a dietary consultant to develop the menus, then they really should follow them as far as ordering is concerned and for those residents.

Q. (BY MR. LAYMAN): Okay.

A. This other particular resident, too, that was the head injury, he also did not have heel protectors on. He had orders for the clavicle strap to adjust his position when he was up, and that was not on. This was ordered by the physician. One lady had had surgery to her eyes and there were orders for sunglasses to be on, and she was observed in the room without sunglasses.

HEARING OFFICER PARRISH: Do you know in that case whether her sunglasses were available?

MS. ROBBINS: Yes, they were.

HEARING OFFICER PARRISH: Do you know why sunglasses weren't in place?

MS. ROBBINS: No. It was clearly posted above her bed that she was to have sunglasses on.

MR. QUINLAN: Could it have been that she knocked them off?

MS. ROBBINS: No. They were lying on her bedside table. And that's most of the things that I can speak to at this revisit.

Q. (BY MR. LAYMAN): During this survey of May the 20th, would you say that most, all or some of the residents you observed were receiving less than adequate care?

A. Some. There had been—since this was a revisit, there had been some improvement.

Q. What I'd like for you to do now is, based upon your observations during these three resurveys, revisits, May 20th, the August and the October, would you describe the progress or lack of progress you saw made chronologically from May up and until October?

A. The May revisit there had been, as I stated before, some progress since the previous survey, which was the one in March. We then went back in in August to do a full survey, and again we found conditions that were less than adequate due to the fact that the nursing and the dietary, infection control, all of those conditions were out. Then when we went back in October to do the special revisit again only on the conditions of participation, which reflected nursing, dietary, infection control and the environment. We found the conditions worse at this particular time. The one particular day that we went in, the conditions were deplorable.

Here follows the second public document named on page one, *The Initial Order of the Presiding Officer*, in its entirety.

BEFORE THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

In the Matter of U.S. Care Corporation
and Kansas Health Care Systems Limited
Partnership, d/b/a Wichita Care Center   Case No. 85-H-99
1319 West May
Wichita, Kansas 67213

INITIAL ORDER

The above captioned matter was brought on for hearing on the 17th day of December, 1985, in Room N, Kansas State Capitol building and was continued on the 30th day of December, 1985, at the Kansas Department of Health and Environment, Forbes Field, all in the City of Topeka, Shawnee County, Kansas, pursuant to notices mailed to parties on December 5, 1985, and December 20, 1985, respectively.

Complainant, the Kansas Department of Health and Environment, appeared by its counsel Frank W. Layman. Respondent U.S. Care Corporation and Kansas Health Care Systems Partnership d/b/a Wichita Care Corporation appeared by its counsel Jack A. Quinlan. This matter was commenced pursuant to the Kansas Administrative

Procedures Act, Chapter 313, 1984 Sessions Laws of Kansas under authority found in K.S.A. 39-931, as amended.

A prehearing conference was scheduled and held at 1:30 p.m., November 25, 1985, during which the parties stipulated, *inter alia*, that the issues to be decided in this matter shall be limited to violations described in Paragraphs No. 6 and 7 of the "Notice of Commencement of Adjudicative Proceeding and Appointment of Presiding Officer."

FINDINGS OF FACT

1. Respondent acquired and began operating an adult care home know as Wichita Care Center on or about the 14th day of February, 1985, under a short-term license issued by the Kansas Department of Health and Environment, the Complainant in this action. Wichita Care Center was issued a Skilled Nursing Home License for the care of 149 persons, of which a maximum 35 were permitted to be "skilled nursing care" or "heavy care" residents, the balance being "supervised nursing care" residents. This short-term license was issued for the period February 14, 1985, to May 31, 1985.

2. The Wichita Care Center consists of a facility located on approximately 14.6 acres of land constructed in 1906 with addition constructed in 1947. Prior to its acquisition by Respondent in February, 1985, this facility was operated as an adult care center under various owners and various titles including Seneca Manor and Florence Health Care Center. The facility did not have a good reputation as a quality nursing home and was the subject of at least two revocation hearings prior to its acquisition by Respondent.

3. On or about March 25, through April 1, 1985, Complainant surveyed Wichita Care Center and found a number of deficiencies in violation of state and federal rules and regulations. As a result the Complainant (hereafter referred to as either "KDHE" or "Complainant") determined Wichita Care Center to be in substantial noncompliance with state license requirements and issued an order revoking Respondent's license to operate an adult care home. The parties entered into a settlement agreement under which Respondent's license was continued until May 31, 1985, on the condition that Respondent would prepare a plan of corrections of the deficiencies identified in two survey reports (H&E Exhibits No. 2 & 3). On the further condition that the plan of corrections was sufficiently implemented, Complainant agreed to issue a provisional license for six months to Wichita Care Center. After follow-up visits were conducted by plaintiff, a provisional license was approved for the six-month period beginning June 1, 1985, through November 30, 1985. The license approved a total of 149 residents, no more than 35 of which could require skilled nursing care.

4. Respondent made application for renewal of its adult care home license on an application received by KDHE on July 14, 1985, and Respondent applied for certification in the Medicare and/or Medicaid program in an application dated August 23, 1985. As a result of its application for license renewal, Complainant conducted detailed inspections or surveys beginning August 19, 1985, through August 23, 1985, in which it identified numerous deficiencies in violation of state and federal rules and regulations for licensure and certification. In a letter dated September 10, 1985, Respondent was notified of the facility's noncompliance with certain federal conditions of certification and could not be recertified. Respondent was notified that a revisit would be conducted in the "near future" for purposes of ascertaining the status of correction of these deficiencies (H&E Ex. No. 15). Complainant issued a Correction Order on September 24, 1985, detailing the violations which resulted in noncompliance. On September 18, 1985, Respondent prepared and submitted a Plan of Correction which was returned as "unacceptable" by Complainants to Respondent on September 25, 1985. Respondent stipulates that the deficiencies existed and the resulting violations alleged following the August surveys occurred.

5. Complainant conducted revisits of Wichita Care Center on October 14, 15, and 16, 1985, and found deficiencies quite similar to those found during the August surveys. Sue Robbins testified that the conditions in October were worse than they were in August; Complainant's allegations specify the same violations. The deficiencies discovered in August and October are numerous and serious in nature. No significant improvements were made in the condition of Wichita Care Center by the time of October revisits. Respondent stipulates that deficiencies existed and the resulting violations alleged following the October revisits occurred.

6. The conditions detailed in Complainant's Order of Revocation (H&E Ex. No. 5) which are based on March surveys parallel the details described in the testimony of Sue Robbins, both of which describe a deplorable lack of cleanliness, proper treatment of the residents and the total lack of attention to the physical and mental needs of the several residents described therein.

7. Complainant repeatedly warned Respondent of the need to improve conditions at Wichita Care Center. As early as February 14, 1985, when it issued a short-term "Change of Ownership License" to Respondent, Complainant stated that unspecified corrections to deficiencies were needed. From the point in time of the May 13, 1985, settlement agreement (H&E Ex. No. 6) to the issuance of the provisional license which took effect June 1, 1985, Complainant made several attempts to assist Respondent in its effort to achieve compliance and in issuing a provisional license, continued to put Respondent on notice of its need to make improvements to its facility.

7a. After its surveys in August, 1985, Complainant used the occasion of its notice of noncompliance for certification as well as a Correction Order to alert Respondent to the need to bring certain standards into compliance to qualify for relicensure and certification at the end of the period established for provisional licensure.

8. The conditions at Wichita Care Center improved after the March surveys but deteriorated between May 28, 1985, and the dates of the August surveys.

9. When U.S. Care Corporation made application for a change of ownership license prior to February 14, 1985, Complainant conducted a background investigation confirming that U.S. Care Corporation operated adult care home facilities in several states in compliance with state laws and regulations. There were no apparent adverse proceedings in process in these other states.

10. In approving its change of ownership license, Complainant does not conduct an in depth survey reflecting nursing care, dietary standards, infection control and environment. Instead, the survey is limited to inspection of the physical plant of the facility. There is no evidence to show Wichita Care Center was in compliance with these operational standards immediately prior to Respondent's acquisition or immediately thereafter.

11. On or about the 14th day of February, 1985, U.S. Care Corporation assumed control and was licensed to operate six adult care home facilities in the State of Kansas. There have been no complaints emanating from its takeover and operation of the other five facilities in Kansas. One of these was operating under a provisional license and was granted a full license under Respondent's operation.

12. U.S. Care Corporation operated 52 care homes in 13 states as the date of this hearing. It has been in the business of operating care homes since 1979 and actively has been acquiring adult care homes for approximately two years since the end of 1983.

13. In order to respond to the immediate needs of Wichita Care Center in the 90 days following its acquisition, U.S. Care Corporation brought in a team of specialists referred as the "pride team" which had the mission to bring all aspects of resident care into compliance with state and federal rules and regulations.

14. The biggest single problem in operating Wichita Care Center was the problem of obtaining and retaining competent personnel. From the time of its acquisition until November, 1985, the nursing home administrator Marsha Mullins experienced difficulty in hiring competent personnel. She had no fewer than four persons serving in the position of director of nursing and four persons serving as the food service supervisor. She experienced a 300 percent turnover in certified nurses' aides, a 150 percent turnover in licensed practical nurses and a 156 percent turnover in registered nurses.

15. Wichita Care Center employs 110 persons most of which are full-time employees. Only 25 to 33 percent of the employees who were on board June 1, 1985, were still on board as of the 30th day of December, 1985.

16. In addition to personnel problems in the facility, it is apparent from the testimony of Walter Powers, Ph.D., and William E. Whitely, Jr., that U.S. Care Corporation had inadequate managerial staff initially to supervise the operation of its adult care home facilities.

17. Dr. Powers began work as the regional manager for the newly acquired Kansas facilities on or about the 1st of September, 1985, nearly seven months after acquisition. The record indicates that a man had been in charge of supervising these homes but had not done an adequate job; it is not clear how many homes this unnamed man was responsible for supervising.

18. William E. Whitely was hired by U.S. Care Corporation in May of 1985 and ultimately was placed in charge of the western division which includes Louisiana, Missouri, Arizona, California and Kansas. His title is Assistant Vice-President of Health Care Operations for the Western Division. Mr. Whitely was hired to take on part of the responsibilities of a company vice-president named Clark Davron who currently is in charge of the eastern division. It was not until August that Mr. Whitely first came to Kansas in his new supervisory role. After visiting each of the six homes in Kansas, Mr. Whitely immediately began a search for a Kansas regional manager and Dr. Powers. Beginning in September of 1985 and through the months that followed through the end of the year, Mr. Whitely spent approximately 27 days working at Wichita Care Center. Mr. Whitely was working under the general guideline of his immediate supervisor, Mr. Winston Stephens, who described to Mr. Whitely a two-part commitment or mission for Wichita Care Center: first, to bring the facility to a licensable status through the use of the "pride team" and second, to bring Wichita Care Center into full compliance during the six-month period of the provisional license.

19. The record shows that Mr. Whitely was assigned to deal with problems in U.S. Care Corporation's operation of two recently acquired adult care homes in Arizona. One was Death Valley Care Center which had been operating under a provisional license and a correction order. That facility has recently been issued a new full license.

20. The second facility is known as Mountain Aire Health Care Center of Phoenix, Arizona, which has a recent history of deficiency reports similar to the reports of recent surveys of Wichita Care Center. Evidence of the circumstances surrounding deficiencies and corrective actions directed toward Mountain Aire Care Center was incomplete and presented quite late in this hearing in an attempt to impeach evidence presented in support of Respondent's capabilities and good intentions with respect to Wichita Care Center. It is unclear when Respondent acquired Mountain Aire Health Care Center, but the record implies it was a recent acquisition of a facility which had severe personnel problems and lacked the ability to provide an adequate level of resident care. Under the terms of a consent agreement (H&E Ex. No.22) Respondent U.S. Care Corporation consents with the Director of the Arizona Department of Health Services to immediately relocate 15 patients requiring skilled care and authorize expenditures necessary to bring Mountain Aire Health Care Center into complete compliance. Respondent agrees to take corrective action in several other areas in order to bring the facility into compliance. Complainant herein introduces an "Order for Summary Suspension of Licenses" (H&E Ex. No. 23) as additional evidence of Respondent's failure to comply with the Arizona Consent Agreement. This Order enumerates deficiencies and violations which "have resulted in serious injury and/or death of patients" and currently present "life-threatening situations." The evidence further shows that U.S. Care Corporation sold Mountain Aire Health Care Center to another entity.

21. The reference to the Arizona home further lends support to the finding that U.S. Care Corporation was expanding too rapidly for the administrative staff to handle. Homes were acquired which had serious operational difficulties, and U.S. Care was incapable of addressing these difficulties.

22. Although no Correction Order was issued by Complainant and no Plan of Correction was submitted by Respondent following the revisits in October, Respondent, through its employees Marsha Mullens, nursing home administrator of Wichita Care Center, and Dr. Powers, prepared and introduced into evidence (Respondent's Ex. No. 2) a notebook entitled "Documentation of the Correction of Deficiencies" of the October revisits. This notebook contains approximately 500 pages of documentation referencing appropriate state and federal regulations and was prepared after November 15, 1985. The testimony of Marsha Mullens indicates that corrective action began immediately after the October revisits and was completed by December 1, 1985.

23. The evidence establishes that Respondent, through special attention and special effort, was able to reduce the number of deficiencies and increased the level of compliance within the two and one-half months following the March survey, but that permanent, lasting improvements in the condition of this facility would require between six and twelve months to complete. Respondent's efforts prior to the issuance of the provisional license constituted the necessary corrective action for compliance, but were insufficient to have the lasting effect necessary to correct the longstanding weaknesses of the Wichita Care Center.

24. From and after the issuance of the provisional license which took effect June 1, 1985, conditions at Wichita Care Center regressed to the status of noncompliance, and Respondent was not prepared administratively to respond to deficiencies and violations which were discovered in the August surveys.

25. Although belatedly, Respondent was making plans independent of the motivation that may have been created

by the negative surveys in August to add the administrative strength necessary to operate its newly acquired adult care centers in Kansas properly.

26. The uncontroverted testimony presented by Respondent regarding the state of compliance of Wichita Care Center from and after the October revisits and prior to December 1, 1985, would indicate that Wichita Care Center was in substantial compliance with all state and federal rules and regulations by December 1, 1985.

27. An examination by Respondent's witness Lee Lanning in September, 1985, indicate that considerable improvements had been made in the operation of Wichita Care Center since his first visit in May. Specifically, Mr. Lanning found the facility to be much cleaner; that there was more structure to the organization evident in the nursing department, and ancillary care services were performed in a more professional manner. Mr. Lanning's visits in May and September were made on behalf of a client considering financing of U.S. Care Corporation's acquisitions and not as a consultant or agency for U.S. Care Corporation. Mr. Lanning surveyed Wichita Care Center on December 11, 1985, at the request of Respondent and found that Wichita Care Center was in substantial compliance in all areas with the exception of infection control which was not in time with compliance procedures.

28. As a result of the October revisits, Respondent retained Helen Darling, a professional consultant specializing in administration and medical records, to assist in bringing Wichita Care Center in compliance. She visited the facility nine times in October, 17 times in November and seven or eight times in December. Among other things Ms. Darling helped in the preparation of an in-service schedule (Respondent's Ex. No. 5) for continuous training of staff of the facility. She testified that the lack of competent staff was a major contributing factor to the problems the facility had experienced during the period of its provisional license, and she stated that the staff as of November 15, 1985. was competent to maintain adequate care if it continues training, supervision and surveillance.

29. Respondent introduced considerable evidence confirming that Wichita Care Center achieved substantial compliance with all state and federal rules and regulations on or before November 30, 1985. Such evidence comes from several witnesses including nursing home administrator Marsha Mullens; Robert W. Bingaman, M.D., who serves as Wichita Care Center's Medical Director; consultant Helen Darling, Regional Manager; Walter Powers; and Assistant Vice-President William Whitely. While it is true these individuals either were employed or retained by Respondent, their profession qualifications are well established and their testimony is credible. Hearsay evidence presented as written statements of Nysel Boggs Hall and Frances Rogers, R.N., M.N., were admitted into evidence but are given virtually no weight because these individuals were not called to testify and were not available for cross-examination.

30. The evidence proves there is a much greater likelihood for Wichita Care Center to remain into compliance as a result of improvements made after October 16, 1985, than as a result of the improvements which brought about temporary compliance in late May. The problem of obtaining and retaining competent staff has been addressed by concentrating on improving working conditions and attracting qualified people instead of utilizing an outside group called the "pride team" which was used earlier to help bring the facility into compliance. Competent supervisors and consultants have been hired to focus their attention on permanent, lasting improvements in the quality of the facility and care to residents at Wichita Care Center. Mysel Boggs Hall who is employed by Respondent as Administrator of the Alma Manor in Alma, Kansas, served as a nursing consultant and assistant administrator to help implement permanent corrective action. Frances Rogers, an expert in analyzing problems in nursing and training nurses, was retained to prepare an evaluation for Wichita Care Center and make recommendations.

31. Under the direction of Dr. Powers, an extensive program for recruiting and retaining competent staff members has been implemented. Of the approximate 110 employees, 25 were terminated because of lack of competency. Wages were increased to a level competitive enough to attract employees to Wichita Care Center notwithstanding the negative reputation this facility has attained. A competent director of nursing and competent director of food service and laundry have been hired. A full time recruitment and personnel director has been hired and placed in charge of in-service training. Shortly after the October revisits, Respondent voluntarily closed "A" wing in one of the original buildings of the facility and voluntarily decided to relocate approximately 14 skilled nursing care residents. Conditions in "A" wing were particularly serious. The total number of beds available has been reduced from 149 to 98. Respondent has made numerous improvements to the facility including renovation of "B" and "C" wings, installation of a new parking lot, new roofing, new machinery and equipment for nursing and for the laundry, new bedding and new furniture. Additionally, Respondent has initiated repairs and improvements to the electrical wiring, plumbing, flooring, boiler, wallpaper, air conditioning, radiators, radiator covers and glass.

32. The evidence shows U.S. Care Corporation has made a substantial financial commitment to Wichita Care Center and is prepared to continue to do so. Expenditure summaries compiled in volumes I through IV (Respondent's Ex. No. 6) indicate expenditures far exceeding the normal operation and maintenance of Wichita Care Center. Testimony indicates that approximately $250,000 has been spent on capital improvements with preliminary plans in the offing to continue in making capital improvements necessary to modernize this facility. Dr. Powers estimates that approximately $200,000 was committed by U.S. Care Corporation to employ experts and consultants to assist in bringing the facility into substantial compliance with federal regulations. Although Dr. Powers indicated a need for improvements in the kitchen and laundry facilities and indicated a possibility that "A" wing might be renovated, he did not suggest any specific plans to make further improvements except to say that the "corporate maintenance director" toured the facility recently to determine whether "A" wing should be replaced or rebuilt. Dr. Powers indicated that capital improvements budgets have not yet been approved, and final authority for any improvements would be forthcoming from Respondent's corporate headquarters.

33. At the request of the presiding officer, Respondent supplied an audited financial statement for U.S. Care Corporation, for the fiscal year ending April 30, 1985. Because the statement was not supplied until nearly 30 days after the record was closed in this case, there was inadequate time for all parties adequately to analyze its contents. Therefore, the decision in this matter will not be based on information contained therein.

CONCLUSIONS OF LAW

The purpose of this proceeding is to determine whether Respondent's application for licensure should be denied because of Respondent's substantial failure to comply with the requirements, standards, rules and regulations established under the Adult Care Licensure Act and whether certification for Title XIX Medicare and/or Medicaid should be denied or not renewed. Several issues were raised during the course of the hearing that require preliminary disposition.

1. At the prehearing conference, the parties stipulated that the issues to be decided in this matter are limited to violations reported following the August surveys and October revisits. Complainant asserts its right to present evidence of violations which occurred prior to those surveys in order to establish a pattern of repeat violations. Respondent objects to such evidence based on the stipulation. The stipulation was encouraged by the presiding officer in an attempt to narrow the scope of this proceeding. Complainant's attorney argued that he intended to enter into a stipulation which would allow introduction into evidence of prior violations for the sole purpose of proving repeat violations which under K.S.A. 39-931 (a)(b)(1) constitutes grounds for denying a license. Because of the possibility of misunderstanding at this prehearing conference and because of the necessity of reviewing all circumstances surrounding the acquisition of Wichita Care Center by Respondent and the subsequent events leading up to this action, it is hereby determined that evidence of violations prior to the August surveys and October revisits should be admitted and considered, and any objection to the admission of such evidence is overruled.

2. Complainant objects to the introduction of evidence to show certain actions were taken by Respondent to remedy any deficiencies cited in the August surveys and October revisits on the theory that Respondent had sufficient time since acquisition of Wichita Care Center to bring the facility into substantial compliance with state and federal rules and regulations. Complainant states that any proof of Respondent's ability to achieve compliance after reports of serious violations does not forgive the violations, particularly in view of the fact that Respondent had recovered in May from a similar set of violations only to let its facility deteriorate to a status of multiple deficiencies in August and October. Respondent seeks not only to prove recovery from these deficiencies but to prove that its recovery after the October revisits resulted from a more permanent approach to correcting deficiencies than it had taken following the March surveys. Respondent argues those activities coupled with other positive steps are sufficient to prevent a finding of substantial noncompliance which if determined as a matter of law would require an order denying licensure. To sustain Complainant's objections would be to preclude consideration of valuable information relating to the progress being made by Respondent toward substantial compliance. Therefore, Complainant's continuing objection in this matter is overruled. The result might be otherwise if this action had been commenced to revoke or suspend the provisional licenses under which Respondent was operating until December 1, 1985. It is not necessary at this time to reach a conclusion that either a revocation or suspension action would be more restrictive. It is determined, however, that this action seeking to deny licensure to take effect on December 1, 1985, should be open to all evidence of all events which transpired from the date of acquisition to the date the provisonal license expired.

3. K.S.A. 39-931(a)(b)(1) provides that repeated violations are grounds for denial of an adult care home license. The language of the statute is permissive and contemplates a review of all the facts surrounding the repeat violations. Complainant has proven repeat violations with evidence of deficiencies prior to June 1, 1985, and evidence of similar deficiencies discovered in August and October. However, based on all the evidence presented in this matter, licensure should not be denied by the reason of these repeat violations.

4. Respondent stipulates to the violations reported following the August surveys and the October revisits. Respondent does not deny the violations reported from the March survey. The issue then becomes whether or not the evidence presented requires a finding of "substantial failure to comply with the requirements, standards or rules and regulations established under this act . . ." which required an order denying licensure pursuant to K.S.A. 1985 Supp. 39-931. In its brief Complainant cites *Boswell, Inc. d/b/a Reno County Adult Health Care Home vs. Harkins, 230 Kan. 610, 640 P.2d 1202 (1982) which states:*

> ". . . the development, establishment and enforcement of standards (1) for the care, treatment, health, welfare and comfort of individuals in adult care homes licensed by secretary of health and environment and (2) for the construction, general hygiene, maintenance and operation of said adult care home, which, in the light of advancing knowledge, will promote safe and adequate accommodations, care and treatment of such individuals in adult care homes."

The purpose of this act is being served if the residents are receiving the standard of care defined in state and federal rules and regulations in an environment of stability and permanency. A careful analysis of all the evidence in this case leads to the conclusion that Wichita Care Center was operating in such an environment in substantial compliance on November 30, 1985, the expiration date of the provisional license. The circumstance precludes a finding of substantial noncompliance. However, the path toward this stability and permanency was blotted by serious deficiencies and obvious negligences in Respondent's attention to the provisional standards of care. Thus, it is impossible to justify full licensure at this time. Therefore, a second provisional licensure shall issue to Respondent under the restrictions and limitations stated in the Order set forth below.

A careful analysis of all the facts placed in evidence in this case leads to the conclusion that the purpose of the adult care home licensure act is being served after considering all events which led up to the status of the Wichita Care Center on November 30, 1985, the day the provisional license was to expire. This is not to say that Wichita Care Center operated in substantial compliance throughout the six-month term of the provisional license. However, the facts and circumstances as presented in this hearing preclude the finding of substantial noncompliance.

POLICY REASONS

The decision not to deny licensure in this case results from the absence of the finding of substantial failure to comply and the discretionary decision not to use repeat violations as the basis for denial. These conclusions result from the weight of the evidence given to Respondent's attempts to bring Wichita Care Center up to proper standards. This is not to say Respondent at all times properly managed its affairs; in fact, Respondent was dilatory and irresponsible in failing to continue to make improvements in the facility and its operation immediately after the issuance of the provisional license.

Respondent began operating adult care homes in 1979. It did not move aggressively into multi-unit operations until 1983, and by 1985 was operator of 52 units. During this expansion Respondent obviously did not plan adequately for supervision, and its failure to do so allowed it to lose control of Wichita Care Center and at least one other low quality unit which ultimately had to be sold.

The evidence indicates some movement toward providing adequate supervision by the hiring of William Whitely to assume control of the western division. However, by August, Mr. Whitely had done too little too late, and although an intensive effort began to improve conditions at Wichita Care Center after Dr. Powers came on board in late August, there seemed to be overconcentration on physical improvements and not enough attention to patient care. Furthermore, constant reminders issued to Respondent by Complainant as early as February 15 and as late as the end of September repeatedly pointing out the need for improvements did not stir the sense of urgency required to achieve sustained and lasting progress until the report of the October revisits was distributed.

If the purpose of the adult care home licensure act was to punish operators for allowing substandard care, then quite possibly this Respondent should not be licensed to operate Wichita Care Center. The purpose is, however, to promote the high quality care and treatment and provide for the health, welfare and comfort of care-home residents using the highest standards of cleanliness and operation K.S.A. 39-924. Respondent has reached this standard, or nearly so, and did so by the time of the expiration of its provisional license.

Although Respondent is to blame for the poor supervision and attention during the early months of provisional licensure, Respondent was faced with upgrading a very old facility that had experienced similar difficulties in the past. Respondent was faced with a veritable nightmare of personnel problems. Turnover was high. Working conditions were poor. Wages were mediocre. Respondent initially ignored the problem and then sought to remedy it with the so-called "pride team." The pride team left, the provisional license was issued and the facility degenerated back to its former state.

Respondent did not willfully or maliciously fail to provide treatment; it simply took too long in developing a sound program that works. There is substantial evidence that a period from six to twelve months would be necessary to bring this facility and the quality of its operations up to standards. If, based on the evidence, the success of Respondent's efforts were to be measured by the status of its progress on December 1, 1985, substantial compliance was achieved in nine and a half months. If Respondent is evaluated solely by the deplorable conditions it allowed to occur at various time prior to December 1, it is easy to conclude that Respondent failed miserably at Wichita Care Center.

Evidence generally indicates that U.S. Care Corporation is a substantial corporation organized with the objective of providing quality health care to elderly citizens. It has used its financial resources and its human resources to meet this objective at Wichita Care Center, although belatedly. Respondent started laying the ground work for permanent changes when Mr. Whitely was hired and when he in turn hired Dr. Powers in late August. As of December 1, 1985, the facility reached a status of substantial compliance. However, for good reasons, Respondent has lost the confidence of Complainant, and until this confidence is regained, Respondent should not be operating Wichita Care Center except under severe restrictions.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED THAT A SECOND PROVISIONAL LICENSE TO OPERATE AN ADULT CARE HOME SHALL BE ISSUED TO Wichita Care Center effective December 1, 1985, and continuing for a period of six months under the following restrictions.

1. Respondents shall maintain its facility and operations in substantial compliance at all times throughout the duration of this provisional license and shall achieve a status of complete substantial compliance by the end of this provisional licensure period subject to agreements with Complainant allowing for certain remodeling activities from time to time which might temporarily interfere with complete substantial compliance;

2. Complainant will designate a consultant of its choice to monitor on a full-time basis the status of Respondent's operation and report to Complainant; said consultant shall be paid in full by Respondent;

3. The "A" wing of the facility shall remain closed until it is completely remodeled or completely rebuilt to the satisfaction of Complainant and shall not be reopened until after complete inspection by Complainant;

4. Respondent shall submit to Complainant a complete plan of remodeling of the entire facility for approval by Complainant prior to the end of the provisional licensure period which expires May 31, 1986;

5. Respondent shall make application for licensure immediately, and Complainant shall waive the 120-day requirement specified in K.A.R. 28-39-77;

6. Respondent shall be limited to a maximum of 98 residents, no more than 10 of which shall be classified as skilled nursing care residents until Complainant authorized additional residents;

7. Respondent shall continue to employ competent personnel at Wichita Care Center and shall at all times have in its employ a regional manager with responsibility for overseeing a maximum of the six Kansas adult care homes and a division manager continuously available as is Mr. Whitely to provide administrative and supervisory support to the regional manager;

8. Respondent shall not during the pendency of this provisional license proceed with any acquisition of other adult care centers in the State of Kansas.

CERTIFICATION

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that certification should be renewed during the pendency of the second provisional license under 42 CFR 442 for the reasons stated in this Initial Order that Respondent is in substantial compliance with federal regulations for certification as of December 1, 1985.

REVIEW PROCEDURES

This Initial Order shall become effective and shall become the final order 30 days after service, provided no party has filed a Petition for Review by the Secretary of Health and Environment and provided the secretary has not given written notice or an intention to exercise such review.

Any party to this action may petition the Secretary of Health and Environment for a review of this Initial Order; such petition must be filed with the secretary, or any person designated for this purpose by rule or regulation of the agency, within 15 days after service of this initial Order. Should the secretary on its motion decide to review this Initial Order, the secretary shall give written notice of such intention to review within 25 days after its service.

Any party within 15 days after service of a final order may file a Petition for Reconsideration with the secretary stating specific grounds upon which relief can be granted. The filing of the Petition is not a prerequisite for seeking administrative or judicial review.

Judicial review of a final order may be obtained by any party under The Act for Judicial Review and Civil Enforcement of Agency Actions, K.S.A. Chapter 77, Article 6, Section 601-627.

IT IS SO ORDERED.

Jim Parrish
Presiding Officer

CERTIFICATE OF SERVICE

The undersigned hereby certifies that he hand delivered a true and correct copy of the above and foregoing Initial Order on the 25th day of February, 1986, to the following attorneys of record:

Mr. Frank Layman
Attorney at Law
Kansas Department of Health and Environment
Forbes Field
Topeka, Kansas 66621

Mr. Robert Hecht
Scott, Quinlan & Hecht
3301 Van Buren Street
Topeka, Kansas 66611

Jim Parrish
Presiding Officer

And last, the third public document named on page one, *Notice of Review of Initial Order*, also in its entirety.

BEFORE THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

In the Matter of U.S. Care
Corporation and Kansas Health
Care Systems Limited Partnership,
d/b/a Wichita Care Center,
1319 West May, Wichita, Ks. 67213 Case No. 85-H-99

NOTICE OF REVIEW OF INITIAL ORDER

Now on this 10th day of March, 1986, the Secreatry of Health and Environment, on her own motion, decides to review the Initial Order in the above entitled case issued Febraury 25, 1986, by Jim Parrish, presiding officer. Pursuant to authority granted in K.S.A. 1985 Supp. 77-527, Barbara J. Sabol, agency head of the Kansas Department of Health and Environment, hereby gives written notice of her intention to review the Initial Order. The issues that I intend to review are:

1. Whether the Initial Order of the presiding officer granting a second provisional license to Wichita Care Center effective December 1, 1985, and continuing for a period of six months under certain restrictions was in compliance with Kansas law (K.S.A. 39-931a) and agency policy based upon the facts in this case,
2. Whether the Initial Order renewing certification under 42 CFR 442 and 42 CFR 405.1908 was proper in light of the facts in this case.

Pursuant to K.S.A. 1985 Supp. 77-527(e) each party is afforded an opportunity to present briefs on these issues I intend to review. Any party desiring to submit a written brief must do so within fifteen days from the date of service of this Notice.

IT IS SO ORDERED.

Barbara J. Sabol
Secretary of Health and Environment

CERTIFICATE OF SERVICE

I hereby certify that on this 10th day of March, 1986, a true and correct copy of the above entitled Notice of Review of Initial Order was mailed by depositing in the U.S. Mail, certified, return receipt requested to: Mr. Robert Hecht, Scott, Quinlan, & Hecht, 3301 Van Buren St., Topeka, Ks. 66611, attorney for U.S. Care Corporation and Kansas Health Care Systems Limited Partnership d/b/a Wichita Care Center and to U.S. Care Corporation, 141 South Adams, Marion, Indiana, and to Kansas Health Care Systems Limited Partnership d/b/a Wichita Care Center, 1319 West May, Wichita, Ks. 67213 and a copy was hand delivered to Frank Layman, Attorney-at-Law, Kansas Department of Health and Environment.

Sandra McCleland
Staff Member

Certified Mail No. P484 308 455
P484 308 452
P484 308 457

KINH News

KANSANS FOR IMPROVEMENT OF NURSING HOMES, INC.
913 Tennessee, No. 2 • Lawrence, Kansas 66044 • (913) 842-3088

Vol. II, No. 3 July 1986
Petey Cerf, Editor

INSIDE KANSAS NURSING HOMES

RE: Nursing Home #44 NC

Number of nursing homes in this town: one

BRENDA: I took my aunt out of #44 in the spring of '85 and put her in Nursing Home S. I think the most serious problem at #44 probably involved the people that are working there. The quality of the people they have for workers and the care that they give in return, it almost goes together. I asked one aide who was working there how much they got and I think he said it was $3.40 an hour. He was a certified aide, not a med aide. He doesn't work there anymore. He got fed up with the place, too. He works at another home now. I have a feeling that he likes the people that he works with better. One reason he quit was that one of the residents at #44 asked him to take him out for a walk and so he went to get permission to do that and the medication aide said, "We don't have time for that." He got fed up then, but that was basically their attitude. "We don't have time to deal with these people."

There were not enough aides at #44.[1] Especially with my aunt, her particular problem is she has Alzheimer's and she was walking all over. So they were confining her to a Geri chair and I had given them permission to use the Geri chair for feeding only but then they continued to abuse that. So I finally said, "Hey, you can't use it at all." But they continued using it. They didn't bother to put anything there for her to play with. Nothing to do and they simply ignored her. They had the chair tied to the railing so she couldn't move around.[3] And the thing that really broke it all was because I went out there during Nursing Home Week. They had various things, and I tried to get out for those, and my husband and I went out for the ice cream social. This was an hour and a half after supper and she was still in the chair and they said, "Well, we were just going to give her some ice cream." But the thing was, they had been working with this stuff, and she was sitting there and she was soiled (she was incontinent).[6] So they did get her up to change her, finally, after I told them. Then, during that time while they were changing her, one of the aides went down there and yelled into the room, "We have to have somebody here to start serving the ice cream." So there the aide went and left just one aide with her and she is a two-person job. I just thought their priorities were a little messed up.

She is a private pay patient. I had a lawyer write them a note because I had spoken to them about the use of restraints and they had agreed with me at the time. I don't know what happened in between but I just decided OK, I'll have my lawyer write up a note. And the only response to that was that we can no longer care for her and would you please get her out of here in two weeks.[5] They said they had to restrain her because she would walk into other people's rooms. And every time I went there was something going on, like they would put her in cloth diapers that didn't fit and I said, "I don't think that is dignified. And you say that you are going to go along with the dignity." I was buying the Depends, but they would run out and I said, "If you would call me or just call the pharmacy to order them." They knew they would be paid for. They wouldn't get stuck with them. They just weren't keeping on top of things. I just thought it was undignified to keep her in a Geri chair and all they were doing, they would be sitting around on breaks, all of them together, and she would be there and maybe trying to get out of her Geri chair and maybe sleeping in it, instead of putting her to bed after the noon meal.[6] And it just seemed like that

About "Inside Kansas Nursing Homes"

Volume II, No. 3, of the KINH Special Series Newsletter continues our report on the quality of nursing home care as seen through the eyes of relatives and friends of nursing home patients.

The procedure followed in the six issues of Volume I will be followed in Volume II, with one exception: comments on nursing home care will be taped, transcribed, and edited to omit mention of non-recent events or references which might pinpoint speakers or patients, but the comments appearing in Volume II, except for this issue, will appear within two months after the conversation took place unless otherwise noted.

Nursing homes mentioned will be identified by a number assigned according to the chronological order in which the comments were received and taped, and the home's location in the six geographical divisions of Kansas will be noted (NW, NC, etc.). If a speaker's comments concern a nursing home previously mentioned in the Series, the home will retain the number originally assigned. The nursing home assigned the highest number in each successive issue will be identical with the number of nursing homes covered by the report to date, except for those homes mentioned only in passing. These will be assigned an alphabetical letter. After Nursing Home Z, the next homes mentioned only in passing will be assigned double capital letters (Nursing Home AA, Nursing Home BB, etc.).

Petey Cerf

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1. Understaffing
2. Turnover
3. Potentially life-threatening
4. Fear of retaliation
5. Non-compliance with state regulations
6. Neglect and/or abuse
7. Inadequate supervision
8. Staff arrogance
9. Staff tasks performed by visitors
10. Prior knowledge of state inspections

The Kansas Department of Health and Environment is responsible for nursing home regulation.

was the way things were going.

She had been at #44 almost a year. And I thought their care had gone down some. *Her* care had gone up some because of the incontinence. But I didn't think her condition had gone up as much as their care had gone down. They had a staffing problem. In fact, their nursing supervisor quit. Both their nursing supervisor and the administrator were new. They had come in at the beginning of that month.

When I first put her in #44, the second day she was in there, she slipped and fell. I'm sure I know what the thing was on that, that they were giving her medication that was too strong and that she wasn't used to and she got up to go to the bathroom and being in a confused state of mind anyway, she wet on the floor and slipped in it.[7] So they brought her in for stitches.[3] Then, the day before I took her out, I got a call that evening saying that she had fallen and would I please come and get her to go get stitches because they didn't have anybody to drive the bus there. So we went out there and I got the incident report for the doctor to sign and all they put down on there was that she had simply spontaneously fallen, which is not what happened. Later they said she did trip over her slipper, but on this particular one it changes the whole way that the doctor is going to look at it because there is a point where she would, with this Alzheimer's, be unable to walk and would spontaneously fall. When her balance goes, which it has gone now, she can't walk now without assistance. But when I showed that to the doctor, the doctor just figured, well, her disease is progressing. This is the fall just before I took her out. The other one, the first one, happened just after I put her in. Now this last time, they said she tripped on a slipper afterwards and I heard another one say that—this same man that is no longer working there—and I don't know what amount of value to put on what he says, but he says she fell outside, she wasn't even inside. And so we are never going to get it straight on that.

There was an aide present when she fell, on the second fall. The thing that they did, they had her sign the report and then the nurse on call was filling it out when I came in. They had this girl sign it *blank*![5]

I had sent for the rules and regulations at Health and Environment so I had that. But I had to fight to get a copy of the incident report. They said it was an internal paper. But I did get a copy of it.

One time when I was at #44, I think it was the noon hour, they had placed the water in front of them before they gave them the food. You know how they have them out there for an hour before they eat. I still haven't figured out the reasoning behind that but they had her sitting there and she had already finished her water and I don't think if I hadn't have been there that anybody would have refilled that for her. If you give her something to drink, that means they are going to have to change her later.[6] About meals—a lot of times she could have eaten more. She could eat OK, so there wasn't a problem with her leaving food that they are taking away. Now toward the last she was having more difficulty with that. I know now in Nursing Home S the meals that she gets, there is more, and it looks like better quality. She is in a Geri chair now because she lost her balance, but she wasn't before.

They are understaffed at Nursing Home S and they know it.[1] And they have had a terrific turnover.[2] I was over there yesterday and I spoke with the administrator and he said they are starting an incentive program with higher pay. Level four or five or something like that going up to $4.75 an hour, for an upper level aide, not an entry level aide. It still is $3.50 there for entry, I think. And he said there is a problem with not coming in, calling in sick, and he said they are starting a program that, with nearly perfect attendance, for the next quarter they could get a twenty-five cent an hour pay raise, making it up to $5.00 an hour. So they are working on that. I have noticed that the people they have working at Nursing Home S just seem to be a higher quality of people. And they don't all take their breaks at the same time.

They have another wanderer and they don't confine him. They watch him. I was real impressed; they know my aunt's problem was wandering and they weren't scared off by it. Wandering is not so much of a problem in Nursing Home S. There is a different wing for where my aunt is. It is a circular wing attached to the rest of the home. They can walk down to the other end if they want to. More people kept their doors closed over here at Nursing Home S than at #44.

I called the Department of Aging when I got the notice about having two weeks to get her out of #44. They said that that was proper. I don't know who I spoke to, but I don't think she knew too much. I asked her what the difference was between intermediate and a skilled nursing home and she said she didn't know. But in reading the manual there, I think it deals with how many people they have to have working on staff. Nursing Home S has a licensed or registered nurse at each station. And it's cheaper than #44 was! They charge for her incontinent care, but I don't fool with buying Depends, and their prescriptions are ordered through a drug store that is associated with, but separate from, the home. My total bill for those three items—room and board, incontinent care, and prescriptions—is the same as just the room and board at #44. Mr. Booth said they are going to have to go up. They haven't gone up in two years. And he said my aunt's would be maybe two dollars a day more. Which is still keeping it under what #44 charged. They're understaffed at Nursing Home S but they seem to handle it.

There was one incident at #44; I wasn't there to witness it. A lady happened to be out there and she called me up and one of the aides had manhandled my aunt. What she had done, my aunt had started to walk toward the dining room area and she grabbed her and spun her around and slammed her down into a chair.[6] I consulted with my lawyer first and wrote a letter up and took it out there. And they said, "Yes, that aide has been reported before." And what they did was suspend her for two weeks. That was it. And she came back after that time and she switched to the cleaning staff. The cleaning staff is there all the time and basically in the way all the time. You can't walk up and down the hall without them being wet or being polished.

And at #44, another thing, they don't have a quiet social area. They have one, but the room is clear down at the end of the hall, but if they are polishing or washing the hall, you can't get to it. And they use that for eating and for meeting purposes for the staff. They have a quiet room that is sort of like a chapel but that is down another hallway, which access is not always the best. And then there's the main room, the living room, and dining room, and they have the TV blaring in there the whole time. Everyone sits around but I don't think they are listening to it.

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And that is what they do in #44, too; they have one TV with one chair sitting in front of it. It is usually on sports and all these ladies were sitting around there, you know, just sitting. One thing, there's an aide at #44, she has been reported by my cousin who is there. She is confined to a wheelchair, crippled with arthritis, and if you pull too hard on her arm it comes out of the socket. And she says (she is 88 and she is still pretty sharp), she said, there are a few of those aides that when she calls, when she has to go to the bathroom, that she just cringes when they come.[6] They just sort of let those aides loose. They give them 90 hours of training and then let them loose.[7]

It doesn't seem like there is much supervision at #44. The nursing person in charge is a medication aide. But I got mad because they had left my aunt in the Geri chair and the LPN that was on duty says, "Well, don't look at me, I'm not in charge of her." And I go, "Well, who is?" And she says, "Well, I don't know."[5] But this is at the end of the shift. This was on a Saturday, no administrative people around.

I do have a little diary thing written up on daily complaints for #44. I was going to write a letter to the Department of Health and Environment, especially on some of these regulation things, like they confine her and wouldn't put her down for how long and there really were no doctor's orders.[5] I don't have it set down in good order or anything yet, but I asked #44 for the copy of the doctor's orders for use of restraints and they sent me the last signed thing, that was actually outdated if it is supposed to be updated every ninety days. They had typed up what the previous orders were and then the doctor would sign them. They never sent me anything that she actually required those restraints. And the doctor has to write down the specific times and reason and there wasn't anything like that and I know there wasn't. I know that nursing homes get bogged down with rules and regulations but it sort of shows what they are doing in general, and their whole attitude, and their whole way of working, and it is sloppy. And at #44, they bathed her twice a week, but I think, being incontinent, that they should have done more. I would clean out her fingernails. And one time that I had to do it was right after she had just gotten out of the whirlpool. They stick them in the whirlpool and they get them out. They don't do anything.[6] She had a skin problem and that was really getting bad over there at #44. Over here at Nursing Home S that is so much more under control. Because like they weren't bothering to even rinse her face off during the day at #44.

At Nursing Home S, she is not as withdrawn, not as frantic. Because now when she has to just sit in that chair, she is not uncomfortable. She is not trying to get out. I think she is in a better frame of mind. Now she is not worried. Nursing Home S is forty miles so I don't get down there every day. I was going every day to #44 which is ten miles, because I felt as though I had to be there. I now like to get down to Nursing Home S once a week.

RE: Nursing Home #45 NE

Number of nursing homes in this town: two

JENNY: My mother had been in #45 for a year and a half. I moved her to Nursing Home U four months ago. When she entered #45, she was fresh out of the hospital. She had had a gall bladder operation. Had stones removed. So she wasn't at her tip-top. That was a traumatic experience but she seemed to spring back from that pretty much. They put her in a wheelchair. They tied her either in a wheelchair or in her bed. They claimed that they were afraid of her falling. They told me that they walked her. My daughter and I walked her at various times. She seemed to do all right. A housekeeper told the social worker that she only saw mother when she cleaned her room, because apparently they would keep her in her room all the time. She had a lot of decubiti when she first got there. I would come in and she would be wet and I would change her.[9] I yelled at the nurses. I got them to treat her. They didn't really change her diapers as often as they should or I don't think she would have had that.[6]

She had been at home with me before her surgery. It got to the place where the doctor said that I was going to have to do something or he would have two cases instead of one. And it was very traumatic for me. It was very much of a turmoil not only having to do this but having her in the situation she was in. And feeling trapped that maybe all these nursing homes were alike. There was one time I went up there and she was tied to the wheelchair—somehow she had stood up but still tied to the wheelchair and she had pottied all around. I was so angry! But I got it cleaned up, got her fairly well cleaned up, finally got a nurse. They did come and they did take her and give her a bath, but the fact is that they left her so long.[6] And if they were afraid of her balance, why wasn't she tied better then in that case?[7]

She was rather confused. The doctor says Alzheimer's. Sometimes she still knows me as family, but she certainly confused the relationship. Many, many times at the nursing home, I would come in and they would put her on that seat in the wheelchair and they would put a diaper, and yank it up through her legs. Not fasten it around her, then they put a duster on her and they put it up high in the back, you know, so it wouldn't get all wet under her.[6] Therefore, it made it higher in front and then I would walk in and she would have the duster up and no diaper around her, and she would be completely exposed.[7] It made me very angry. I said she was a proud woman. She had been an intelligent woman and this is no way for her to be treated.

Now, one thing I found wrong with it, another thing among many—they were understaffed.[1] They had too few aides doing too much work. When she was first there, I could see them up at the desk chatting, having a break.[7]

At one time I was there, she wasn't feeling well, and I asked about putting her to bed and they said, "Well, we don't start putting them to bed until seven."[8] It didn't matter what the resident was feeling. It was just doing what their little schedule was. The owner corporation, which I am very against, raised the rates—this is what precipitated my moving her the last time was another rate change—three times in a year, in less than a year. About four dollars a day, each time.

They spent a lot on interior decorating, large prints, which some residents may enjoy them, but most of them they could care less. They did improve the linens, I think. It needed improving but there should have been a balance of payments. They should have balanced with what they paid their staff and I talked enough to the staff to know that the staff was not reimbursed. They did not get any of the money passed down through the staff. They didn't hire additional help, they were short and they let it go short.[1] At

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the time my mother left, the administrator resigned from the home. The social worker resigned—so did the activities director, a number of the aides, and some of the housekeeping staff. Now one of the aides who was at #45 is at the Nursing Home U where my mother is now. She said she cannot get over the difference in my mother now, because she said she is 100% improved. Not that her mind is clear, but at #45, she would chant and yell. You could hear her from one end of the nursing home to the other. She would do this so when you came in, she was actually hoarse. But now you don't find her doing that apparently, the nurse tells me, it starts when you have been upset by something. But when you get her up and move her around, pretty soon she kind of forgets it.

She is not tied in at Nursing Home U. She is fully ambulatory. They tried her for about two weeks or a month, I forget which, without the diapers, and she did fine for awhile, but then they had to go back to the diapers. She is still having that problem. But she is up. And another thing that impresses me, she is *dressed* out there most of the time. I had nice clothes for her. I bought new clothes because she lost so much weight. Last time she got her driver's license she was 170 pounds and when they weighed her at #45, she was 112.[6] And on the plus side, since she has gone out to this other nursing home, she has gained ten pounds, just since September. They say that she really eats. I think the food didn't look particularly palatable at #45. I cannot compare it with Nursing Home U because I really haven't been there at meal time. But she seems to thrive on it. Her improvement is *not* due to different medication. I went to see the pharmacy bill and she is receiving virtually the same medication. Her improvement is due to love and tender care.

At #45, I never saw water on her pitcher, very seldom, especially not ice water. Tepid water is *yuck*. Especially since she didn't take water—she was never one to drink.

Then another experience, they called me and asked me if they could move Mother. And I said I didn't know any reason. Well, they moved her in a room with another Alzheimer's patient, I imagine, because she was hyper all the time. She says, "I'll sit up. I'll sit up. I'll go to bed. I'll go to bed." She was all the time going on and moving around. In fact, I think she rifled through my mother's closet because I usually organize Mother's closet, you know, tops, slacks, dusters, all together, and kind of check. And when I would go back it would just be a shambles. The fact is that Mother's behavior, well, it seemed to be revving Mother up more. It took me three requests to get her changed again. I requested it two times from the social worker and she said there would be no problem. She would just tell the head nurse and they could change her to another room. So I called the social worker, Rhonda Seely—and she was a doll. She was my life through all of this. If she hadn't been there, I would have probably gone out sooner with Mother. But she suggested since I couldn't get the head nurse to act on it, to go to the administrator, Stacey Turner. And I guess she told the head nurse that, and of course I called Stacey and Mother was changed post haste. But it shouldn't have been necessary to make three calls, one should have done it.

It seemed to me like they are floating their improvements on the back of the private pay patients. It was running, in another raise or two, it would have been up to $46 a day. I know it raised it up so that it is running between $1400 or $1500 a month and her present care, at Nursing Home U, I am getting for less than $1200 a month and even at $1400 or $1500 a month it would be worth the difference.

At #45, they had all these 800 lines all over the place. On the other side, I saw in a financial magazine, they were recommended as an investment. Who would have thought of it as a good investment? We are investing in what we can take away from our elderly. They seem to have enough aides at Nursing Home U. There is one beautiful little lady. She is deaf, but she shines. She's got this shimmering quality. It is love, I'm sure. Apparently she wears a hearing aid, but she has to look right at the people when they talk. She does communicate. She does beautifully. She does a beautiful job and I know that Mother is bonded with her. Mother really thinks she is something. I feel that.

RE: Nursing Home #46 NE

Number of nursing homes in this town: four

Mary Ruth did not know who regulates nursing homes in Kansas.

MARY RUTH: My mother has been in #46 for a little over a year. The care there is very poor.[6] When we entered her, she was getting a little bit mixed up, confused, I'd say, but there was days she was just real clear in her mind and she knew what was going on. She was able to walk around then, which they said she was getting to be a nuisance right after she got down there. She was just walking up and down the corridor and maybe she would go up into the big lounge, you know, and want to visit with people and the administrator, Pauline, says that she was bothering people. My oldest sister would bring all of her clothes home and do them for her. We went down and found her in such a filthy mess that well, like I say, she stayed down there, she would go down every day and clean her. She has control of her bowels. She doesn't the bladder at times. They take her every so often and she will tell them, too. Now last Monday I was down there, and one of my sisters, and for once we walked in and did find her, she did have some decent looking clothes on. My oldest sister furnished the nicest clothes for her and they just throw them in with everything. Their laundry is something else. They don't have decent help. What help they have, Pauline that runs it has her whole family in there; there is about four or five or maybe six little tots running around up and down the corridors. They are her grandchildren.

They have lost Momma's glasses. My oldest sister had to buy her two pairs, then she died of a stroke in December. And since then, well, we have had Momma in the hospital one time. Double pneumonia and all this and we didn't think she would make it this time. She didn't even recognize us kids. There are three of us now. We all live right around her. It is, like I say, the environment is just terrible. If you are able to be up and take care of yourself, you might be able to manage.

She does have a big chair and cushion in her room and she has an accident every now and then with her bladder. And they'll put her in there and shut the door.[6] We went down there many a time since my sister has been gone and they don't know you are coming, and you walk in and open that door and the urine smell is so strong, it will almost burn your eyes.

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She is in a room by herself. A little dinky room. She is private pay. It is costing us $930, $30 a day for every day she is there and that is a lot of money. She gets enough, well almost enough, money to pay her own with her social security and she gets a little pension. And it just isn't enough to go around with the price Pauline charges.

They get no care.[6] And her teeth, something happened to her lower piece and they can't find it. They are supposed to feed her now, she misses her mouth so bad. Malnutrition. And unless some of us go down—we all work, have jobs—you just can't be there every minute of the day. When you pay that price, I don't think it would be asking too much for them to take a few minutes of their time to help feed her.[9] She is not capable of feeding herself. It seems like she aims for her mouth and she doesn't hit it.

She is getting very incontinent. Since they brought her home from the hospital, the doctor ordered them when they had her up to put her in a wheelchair with a restraint. When they put her to bed they do the same way, they put her to bed at 5:30 or 6:00 o'clock, tie her in bed. I have never found out her drugs yet, but I am going to find out what it is. Anyway, they give her her medicine and put her to bed and they have no problem except her bed is just a soaked mess by morning and they just don't put protection on it. They don't put on the plastic. The mattress, it don't last and it smells to high heaven.[6] The other day when I was down there, she was up in her wheelchair and she's got to where she can manipulate that with her hands a little bit and she loves to be around people. Just like a child, more or less. She can't bother anyone because she is in that chair all the time now. They are to walk her three times a day, but whether they are doing that or not, I don't know. They tell us this, but we have caught them in so many different stories that we question them, and I hate to feel that way about anybody. I don't like to cause any problem and I don't want them to get on me for this.[4]

My cousin knows the person in Topeka that is the State Inspector for these homes. And he has talked to him three times because I get so irate when we go down there and see the conditions my mother has to put up with. And since my oldest sister is gone, it is so much worse because the rest of us just can't be down there every minute of the day. At the home they know she is like a child, so they leave her till last. It is just pathetic, and the more we go, we come home and cry and you wonder what you can do. And we have called this inspector back—well, three times we have called him—and asked him please, would he come down and to not let them know he is coming. My cousin knows him real well, because they all work for the state, in a little different field. But this inspector hasn't come yet. We have waited. It has been a good six months. We have called him three different times, and so far they just ignore it. They are going to do it—"Oh, I'll see it is done. I'll be down there."

I would say there might be enough staff, but the staff they have are people they picked up off the street. There are alcoholics, some of them on drugs. And Pauline, this lady that is the manager of it, has a daughter whose name is in the paper maybe once a month, maybe twice a month, for DWI and drugs. And in no time she is right back down there flying around. These people are dirty, not clean. They don't even present themselves well. Pauline's got two sons and this daughter in there. She feeds the whole family, with all these grandkids. It makes these older people nervous at times.

My mom is not the only one not getting good care. Those that are just laying there, vegetables, I'm telling you it is just unbelievable. I'm sure they have to be neglected. The whole place is being neglected. If you are able to be up and walking around on your own and have your mind, those are the only few that get along OK. We have one lady who is a very good friend of ours. She has her own mind. She is the same age as my mom. She kind of keeps us informed of what goes on. She is in a wheelchair quite a bit. She is at their mercy. She has no place to go. She has two nieces and they very seldom ever come to see her. Nobody cares. One lives twenty miles away and one lives thirty miles the other way.

My mother loves a hamburger once in awhile. You don't get meat evidently. So does this lady, and they just look forward to when we go down there. We always take them a burger and a milkshake. And they're just right, they will just gulp them down. And then at the home, they will tell us, "Well, your mom is not eating." She would eat if she had a little help. It is a sad situation and I tell you, I hate to get involved in it and I don't want to be drug through court or nothing.[4] My sister gets so irate. She is pretty nice about it when she tells them but she tells them in a way they know she means business.

RE: Nursing Home #47 NE

Number of nursing homes in this town: four

From a note enclosed with a letter from Irene Cross:

Enclosed is a letter I have written to be used however you see fit. I purposely omitted the name of the nursing home where my father is because of reprisal.[4] (This may not be a concern but the fear is still there.) I was unable to cover everything in one letter but hopefully there is enough to help in some way.

The letter:

Jan. 7, 1986

Kansans for Improvement of Nursing Homes, Inc.

My father is in #47 (a corporation home), where he has been a resident for the past two years. He is 73 and a victim of Alzheimer's disease, in the advanced stage. My husband and I visit him three evenings every week, so we are very familiar with the type of care he receives and the various problems that arise. My mother, who is not well herself, pays for my dad's care. Last month the bill was over $1800, and this month it will include a raise of $4 per day additional charge. Medicare or insurance do not help with this cost. The fear that she may eventually deplete her funds is a constant worry to her. Her health has deteriorated right along with his, due to the hopelessness of the situation she is in. And the fact that she cannot visualize what possible future she could have prevents her from ever getting beyond this point in time. Somehow for a couple married 48 years, never dependent on anyone, living conservatively but comfortably, and always being financially independent, it is understandable why my

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mother is so fearful. My father planned very carefully for their future, but he didn't plan on Alzheimer's disease.

Perhaps the shock of spending thousands of dollars on Dad's care would be eased if we could all have peace of mind that he was well cared for. But this is not always the case. The care problems are numerous and so far we have not felt comfortable leaving him more than two days at a time without checking on him personally. The problems range from hygiene, general daily care, medical and the food. Sometimes he isn't shaved for two or three days at a time. I call and complain and for a short time he is shaved for a few days. Then it all reverts back. Getting him changed is another problem. We very rarely arrive at night when we don't have to find an aide to change him.[6] The doctor left a standing order, two years ago, that he was to be put in bed for a nap every day after lunch. This is not always done.[5] Although he stopped walking this fall, we always walked him in the halls when we were there. He was seldom exercised otherwise.[6] He was never taken outside for fresh air, unless we did it.

When he first was admitted, no one took any in-depth information about him.[7] (Having Alzheimer's I would have thought the staff would be interested in things that might jog his memory.) He has been very passive, and his only "combative" behaviour was to grab someone's arm if they moved too suddenly in front of him. He has always been quiet and no threat to anyone. He requires full care but responds to familiarity and kindness.

In May, he received a black eye and badly bruised arm with two lumps on it.[6] We knew there was no possible way he could have injured himself, due to his condition. A nurse's aide was fired the following day. However, even though more than one aide confirmed that the fired aide had struck him and admitted it to them, abuse seemed impossible to prove because apparently no one actually witnessed it. Since then the injuries have included, on three separate occasions, two deep cuts to his arm, and one at the base of the finger; all results of catching them in the tray on his wheelchair. He cannot move his arms out of the way himself, and I had even attached a note on his tray asking the aides to be careful when removing or attaching it. Still, the injuries happened.[7] Recently he had a bladder infection which resulted from lack of fluids.[3] He cannot ask for a drink himself.

There is a constant turnover among the staff.[2] Agency help is very common. There isn't any information posted in the resident's room to describe the nature of the illness or the individual's routine.[3] There seems to be a general lack of communication and information given.[7] The aides are shifted around so much from resident to resident. (Fri. night, Jan. 3rd, there were only 2 aides and 1 staff nurse on duty for ½ of the nursing home.)

Right now, my dad is having some difficulty eating. The weekend before Christmas, while he was recuperating from his bladder infection, I discovered through a friend who was visiting her husband that Dad had not eaten that day. He wouldn't open his mouth to be fed. This did not go on report, and since he normally ate well, it certainly signaled a problem. I had to call and ask the charge nurse to report it so the shift in the morning would be aware of it. I also suggested they try blended soft food. Instead it took a couple of days to get them to do it.[7] When they finally did blend it, it was nothing but liquid. Even now, I still have to keep on them about it, and now that he is eating better, they won't try more solid type foods unless I keep on them. I am very concerned because I am unable to be there for all of his meals. The food and the menus have definitely deteriorated since Dad has been there. (A recent Sat. night dinner consisted of rice, peas, chopped liver, and yellow jello with brown beans in it. I saw many plates barely touched that night.) Appetizing meals are important and the residents need to eat as well as they can. The amount served seems to be the same regardless of the size or appetite of the residents. Those who have to be fed, or cannot speak for themselves, are not offered extra helpings, etc. What is placed in front of them is what they get.

Yes, I have thought of moving Dad elsewhere but this is a "highly respected" nursing home. Yet I've barely touched on the problems we have encountered. My feeling is that regardless of which nursing home he is in, the problems will be the same, maybe worse. So we have opted to stay and fight the "battles" for improvements, and watch the situation closely.

This past year, the nursing home was completely redecorated along with the residents' rooms. A new hallway was constructed, even though the facility was having difficulty staffing the existing halls.[1] Most of us would have voted for less "improvements" in favor of increasing salaries for the aides and better food provided for the residents, among other priorities. Perhaps the expensive furnishings were meant to draw attention away from the problems that exist.

It is very difficult to watch Dad deteriorate from his devastating illness, and we do not expect the nursing home to make him well again. But preserving his dignity and meeting his daily needs are a top priority, and he is paying dearly for it.

We have suggested monthly meetings between the families and the nursing home, but so far they have not materialized. We are left with a one-on-one situation which doesn't get much solved.

I wish you well in your efforts to seek nursing home legislation. There is so much that needs to be brought out in the open to arouse the public awareness of the very problem they could someday be faced with, involving a loved one. I hope this letter can be added to your list of confirmations that the problems exist. If there is any further information that I can help with, please feel free to ask.

Sincerely,
Irene Cross

P.S. I think I should have elaborated more on the problem of constant turnover among charge nurses and aides. We know the aides are greatly underpaid. (They can make as much money working in a "fast food" place, as caring for a nursing home resident!!) Most of the problems encountered at this particular facility are directly related to the turnover and the inconsistencies are because of it.[2] When help is always being needed, the home cannot be as selective of those they hire, and care problems, including abuse, can result. Although the person responsible is fired, the damage has already been done. (In 2 years time, there is only one nurses' aide left, a very competent person, who was there when my dad arrived, still working in the evening on his side of the home. There have been at least half a dozen charge nurses or more during this time.) For a nursing home located in such a nice area, comfortable

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10. Prior knowledge of state inspections

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surroundings, etc., one would think that those who work there would stay. There is no question that internal problems have contributed greatly to their leaving after such short periods of time. There does not seem to be any communication between staff members, just one placing the blame on another.[7] Information is very limited, and even new charge nurses are not familiar with individual care needs and routines, so it's understandable that the regular aides or agency people wouldn't know either.[8] Someone is needed to take on the responsibility of informing them and overseeing that everything is carried out. The staff simply doesn't understand that they are being paid by the residents to perform these services. This attitude should be deeply instilled in everyone who works there. Why shouldn't those financially responsible for residents have a say in whether their money goes for new drapes or for better and more food? Somehow the priorities and values become distorted, and it is the residents who are short changed and suffer because of it.[6]

Irene Cross

Later comments (taped) by Irene Cross:

I was really quite alarmed at what was happening to my dad at #47 and how, little by little, his condition was deteriorating. I was there so much of the time, and I could see this was happening to him, but I was told that his Alzheimer's was so advanced and this was to be expected. Then we discovered, I guess around the end of the month, that he had a bad ulcerated decubitus.[3] He was suffering from dehydration off and on.[3] And at the end of the month, he was admitted to the hospital to have this sore cleaned out surgically. And five days after he got back to the nursing home, he was returned to the hospital completely dehydrated.[6] There was no urine output. He was suffering heart failure and pneumonia and had a very high fever. And after being in the hospital for three and a half weeks, we chose not to return him to #47. We now have him in Nursing Home T.

While he was at #47, I went through the whole line. I went to the ownership (the corporation), to Linda Todd, who was the administrator then. I kept voicing my concern about my dad, because some nights I would come and find him like very warm, running a temperature and he would have a yellowish tinge to his skin. I knew he was dehydrated.[6] I would call and I went three times a week. I have for two years. And I would call the days I didn't go, and I would say, "Please see that he gets plenty of fluids because he is obviously dehydrated." I talked to Linda Todd. She took over as administrator last summer, I believe it was.

The problem with the whole nursing home was they build an additional hallway and it seems like all the attention went to this new construction and new furnishings and they were redecorating the rooms, but at the same time the care level was dropping so bad. The constant turnover in help.[2] I knew as Dad's condition deteriorated, you know, he couldn't wait until they got things in order. I talked to Mr. Davis, who is the corporation representative here in this region. I talked to him in the middle of that month and I told him I was really concerned with what is going on out there. I was concerned about the food, the lack of staff, and he said, "Well, you will have to give us a little time. We are trying to straighten around. We need input on what needs correction," and this type of thing. And I said, "Well, I don't think my dad has got that kind of time." Dad just kept getting worse and the sore kept getting worse.[3] I could talk to somebody in the morning who could tell me, "Well, it looks better," and then the evening staff would say, "It really looks bad." And this is the way we see-sawed back and forth.

Well, finally at the end of the month we put him in the hospital and this sore was surgically cleaned. After five days he was released and taken back to #47. This was on a Thursday morning. On Saturday night when I walked in the nursing home, there was no air-conditioning.[5] It was a very warm day. It must have been a hundred inside that building. I got back to my dad's room where he was in bed. There wasn't a window open, there was a huge puddle of urine under his catheter bag, and he was way down in his bed; I mean his head was nearly to the middle of the bed with his feet way down at the end.[6] He just looked awful. I jumped the aide right then and there, and as it happened, the doctor, Dr. Greer, came by that evening while I was still there and I told him, "I found my father in just a deplorable condition—he looks just awful." I said I had complained to the head nurse about how I found him; not only that, this aide had given Dad a drink, and I looked after she left the room, and she had used a glass that was marked for cleaning the decubitus.[3] I was just livid. I didn't know what to do because he was so sick. I knew he couldn't be moved to another home right at that given point. I talked to the nursing staff the next day. They assured me they were pumping the fluids into him. They knew how upset I had been over the way I had found him the night before. They were, I think, at least during the day shift, trying to pay attention to him, but then on Tuesday, which was just five days after his return to the nursing home, they called me and were going to rush him to the hospital. He was completely dehydrated.[3] There was no urine output.[3] He had a high fever, he had pneumonia, and he was suffering heart failure. So we got him over to the hospital and they didn't think he would make it through the night, but he did. He stabilized. He spent three and a half weeks there and then we chose not to return him. So he is at Nursing Home T. It is right by the hospital. I just could not send him back to #47.

The strange thing is, the day my dad was released from the hospital the first time on the 3rd, I tried to reach Mr. Davis because I was concerned about my dad coming back from the hospital to #47. I wanted to talk to him and tell him my dad was being released from the hospital. He was in very serious condition and I wanted to know what to expect in terms of care. Well, he never returned my call.[8] The next morning, I met the ambulance out there at #47, but before I went out there, I put in a call to our local ombudsman. I told her, I said, "I am really concerned about my dad, putting him back there." But, I said, "He was released from the hospital quicker than I realized, and at this point he is so sick, I just don't know where to put him. All I can do is try to get someone to oversee what is happening to him." And she put me in touch with Jill Armstrong. She is one of our county nurses.

Now on Monday, the day before my dad was sent back to the hospital the second time, the 7th, Jill Armstrong went out to #47 to see for herself the situation. I know for a fact when she went out there she found no air conditioning because the air conditioning in the building had not

---

1. Understaffing
2. Turnover
3. Potentially life-threatening
4. Fear of retaliation
5. Non-compliance with state regulations
6. Neglect and/or abuse
7. Inadequate supervision
8. Staff arrogance
9. Staff tasks performed by visitors
10. Prior knowledge of state inspections

The Kansas Department of Health and Environment is responsible for nursing home regulation.

worked all spring. It was extremely warm at that time. She went out and checked on that Monday, the day before my dad was admitted back to the hospital in that critical condition. She never reported back to me. I did call our ombudsman back then to see why I hadn't heard from Jill and she said, You should be receiving something from her." Well, I never did. Not a report or anything. Like I say, all I could do was get my dad out of there.

He is stabilized now and he gets excellent care at Nursing Home T. I am so impressed. Of course, it is new. It opened in the fall and it is operated by the hospital and they certainly have done an excellent job with Dad. I am sorry there are so many people that don't know where to go or who to complain to.

KINH News

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APPENDIX 4

DOCUMENTS AND COURT FILINGS PERTAINING TO SMITH v. BOWEN

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLORADO

Civil Action No. 75-M-539

In re the Estate of:

MICHAEL PATRICK SMITH, et al.,

Plaintiffs,

and

PEOPLE OF THE STATE OF COLORADO, et al.,

Plaintiffs in Intervention,

vs.

THOMAS J. O'HALLORAN, et al.,

Defendants.

FILED
UNITED STATES DISTRICT COURT
DENVER, COLORADO

FEB 8 - 1983

JAMES R. MANSPEAKER
CLERK
BY________ DEP. CLERK

JUDGMENT

Pursuant to and in accordance with the Memorandum Opinion and Order signed by The Honorable Richard P. Matsch, United States District Judge, and entered on February 8, 1983, it is

ORDERED, that the claims of the plaintiffs and plaintiffs in intervention against the Secretary of Health and Human Services are dismissed, that judgment is entered in favor of the defendant Secretary of Health and Human Services, that the defendant Secretary of Health and Human Services shall recover his costs, upon the filing of a Bill of Costs within ten (10) days from this date, as against the plaintiffs in intervention from the time of the filing of the complaint in intervention, and that no costs are awarded against the plaintiff class.

DATED at Denver, Colorado this 8th day of February, 1983.

FOR THE COURT:

JAMES R. MANSPEAKER, Clerk

APPROVED:

Richard P. Matsch, Judge

Stephen P. Ehrlich, Chief Deputy

ENTERED ON THE DOCKET
FEB - 8 1983
JAMES R. MANSPEAKER

basic rights protected by the First, Fifth and Fourteenth Amendments to the United States Constitution.

An amended complaint was filed on May 30, 1975. It extended the class allegations to include all Medicaid recipients residing in nursing homes in the State of Colorado. A second amended complaint was filed on June 5, 1975, naming an additional plaintiff, and adding 28 U.S.C. § 1361 as an additional jurisdictional predicate.

A preliminary injunction hearing concerning conditions at Heritage House was held on June 5, 1975, resulting in a stipulation for the adoption of certain procedures for the protection of some of the claimed constitutional rights.

The federal and state governmental defendants challenged subject matter jurisdiction, and the basic questions were briefed extensively. In the plaintiffs' final brief on the jurisdictional and class certification issues, filed on February 17, 1976, the following summary contention is made on page 7:

> Plaintiffs are claiming, in essence, with regard to their first three claims for relief that the federal and state governments are massively failing to discharge their constitutional, statutory, regulation and contract duties to create and implement a comprehensive system of preventive enforcement that is designed to insure compliance by nursing homes with all applicable federal laws guaranteeing provision of high quality medical and psychosocial care in a context of civil liberties to plaintiffs and class members. The reach of the failures of the governmental defendants is state wide, indeed national, with regard to the federal Defendants and the devastating human effects of the government's failures on the human being seeking to form this class action are a national tragedy and a national scandal whose focus for the purposes of this litigation must be limited to nursing homes in the state of Colorado. For

IN THE UNITED STATES DISTRICT COURT
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Defendants.

FILED
UNITED STATES DISTRICT COURT
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JAMES R. MANSPEAKER
CLERK

MEMORANDUM OPINION AND ORDER

This very difficult lawsuit began with a complaint filed on May 16, 1975, by Michael Patrick Smith and Carolyn Finnell, residents of Heritage House Nursing Home, as a civil rights action, seeking remedies under 42 U.S.C. § 1983, for alleged violations of constitutional rights. The action was brought as a class action on behalf of all Medicaid recipients residing in the named nursing home. The defendants were the owners and administrators of that nursing home, Casper Weinberger as Secretary of the Department of Health, Education and Welfare (HEW), and the officers of the Colorado Department of Social Services and the Colorado Department of Health. Plaintiffs asserted that both the federal and state governmental defendants were failing to enforce the United States Constitution, together with federal laws and regulations, resulting in deprivations of

> proper presentation of their first three claims for relief and for effective relief from the Court, Plaintiffs seek the certification of a state wide class comprised of all Medicaid recipients residing in nursing homes facilities participating in the Medicaid Program.

During a series of status conferences in 1976 and 1977, counsel and the court agreed that resolution of the jurisdictional issues would be deferred, pending an effort to establish a fact-finding methodology for surveying conditions in Colorado nursing homes. A law school dean was appointed to assist counsel in working toward that objective. That effort failed.

On March 16, 1978, the jurisdictional issues came on for hearing. At that time, the plaintiffs and the Colorado governmental defendants stipulated to the dismissal, without prejudice, of the claims against those state defendants. That stipulation included the following two paragraphs:

> 1. State defendants shall forthwith file a complaint in this action against the United States Department of Health, Education and Welfare and individuals acting in official capacities therefor, seeking a redesign of the federal Medicaid nursing home enforcement system so that the system is premised upon resident assessment. State defendants shall diligently prosecute said action and shall settle said action only with the consent of plaintiffs; provided, however, that State defendants may dismiss said action at any time, and thereupon, plaintiffs' claims for relief against State defendants shall be reinstated as though this motion had never been filed and dismissal had never been entered.
>
> 2. If the litigation described in paragraph 1 has not resulted in the implementation of a redesigned federal Medicaid nursing home enforcement system by July 1, 1979, State defendants shall, in consultation with plaintiffs, seek to develop State legislation or regulations which

> [illegible] provide for an adequate State nursing home enforcement system. State defendants shall thereupon seek funding from any and all possible sources for the implementation of such a system. This agreement shall in no way interfere with the earlier development and implementation of a redesigned State nursing home enforcement system, independent of this litigation.

Pursuant to the stipulation of dismissal, the Colorado Attorney General filed a complaint in intervention on behalf of the people of the State of Colorado, the Colorado Department of Health, the Colorado Board of Health, the Colorado Department of Social Services, and the Colorado Board of Social Services, on April 21, 1978. The first two paragraphs of that complaint in intervention are as follows:

> 1. The federal system of nursing home regulation and enforcement is a national disgrace. Plaintiffs in intervention, the people of the State of Colorado, the State of Colorado, and its health and social service agencies, bring this action against the Secretary of the United States Department of Health, Education and Welfare, seeking to redesign this system so that it focuses upon resident assessment. Plaintiffs in intervention maintain that this system must assure that residents of nursing homes receive the benefits guaranteed under federal law: the right to actually and continuously receive optimal medical, nursing and psychosocial care, provided in a rehabilitatively supportive, accessible, safe, sanitary, home-like and personalized environment, with protection of residents' civil rights. Plaintiffs in intervention, who are charged with implementing the federal nursing home enforcement system, bring this action on their own behalf, seeking an effective and adequately funded system, and on behalf of the people of the State of Colorado, who are entitled to be assured that the Medicaid and Medicare programs deliver the high quality of nursing home care to which they, as nursing home residents and as citizens and taxpayers, are entitled.
>
> 2. Plaintiffs, formerly codefendants in this action with defendant Secretary, filed this Complaint pursuant to their Motion to Dismiss Without Prejudice

> and Stipulation for Dismissal, filed on March 16, 1978. They seek declaratory and injunctive relief, declaring the Secretary's failure to design an effective nursing home enforcement system to fulfill the mandate of the Social Security Act of 1935 and the constitutional doctrine of intergovernmental immunities and ordering the Secretary to adopt and fund regulations for an effective nursing home enforcement system to guarantee the continuous delivery of the benefits required by federal law.

On April 4, 1978, this court entered an order, pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure, determining that this action shall proceed as a class action on behalf of all Medicaid recipients residing in Colorado nursing home facilities which are participating in the Medicaid Program, and identifying the following common questions of law and fact:

> a. Whether the Defendant Secretary of HEW has a duty under the Social Security Act relative to its Title XIX Medicaid Provisions to develop and cause states participating in the Medicaid Program to implement a system of nursing home enforcement which assures that Medicaid recipients residing in nursing home facilities certified for Medicaid Program participation are actually, continuously receiving their Medicaid entitlements to optimal medical and psychosocial care in safe, sanitary, rehabilitatively supportive, accessible, personalized environments and in a context of full civil liberties as a condition of such facilities' receipt of Federal and State financial reimbursement from the Medicaid Program, and
>
> b. Whether, assuming the Secretary has such a duty, he has adequately or sufficiently discharged or breached it by the present challenged system of nursing home enforcement which he has promulgated and required the states to implement as a condition of their participation in the Medicaid Program.

After extensive pre-trial developments, this court ordered the separate trials of the claims against the federal defendant and the nursing home defendants. On August 6, 1980, the plaintiffs, plaintiffs in intervention, and federal defendant filed a joint motion for a stay, based upon proposed regulatory revisions issued on July 14, 1980. That joint motion included the following paragraph:

> Since from the standpoint of plaintiffs and plaintiffs-in-intervention, the ultimate objective of this litigation is to achieve a change in the survey/certification system directly along the lines now apparently being pursued by the Federal defendant, it makes sense to stay these proceedings and channel their energies into supporting and improving the regulatory proposal which the Department is now considering. However, in joining with the Federal defendant in a request for a stay, plaintiffs and plaintiffs-in-intervention wish the Federal defendant to understand that it is their firm intention to proceed to trial on this matter as expeditiously as possible if the process now commenced which forms the basis for the Joint Motion for Stay breaks down.

The proposed change in regulations never was adopted. Accordingly, the claims against the federal defendant were presented in a full trial to the court from May 17 to June 4, 1982. Pre-trial and post-trial memoranda were filed.

The testimony presented at trial and the voluminous exhibits introduced into evidence have given this court a complete history of the administration of the Medicaid Act by HEW and, later, the Department of Health and Human Services (HHS) with respect to the state's certification and inspection of nursing homes. For purposes of this opinion, the term "nursing home" includes skilled nursing facilities and intermediate care facilities. Additionally, all further reference to "plaintiffs" includes plaintiffs in intervention.

From the great mass of evidence presented at trial, there are some general findings which can be made with complete certainty. The development of nursing homes as providers for those who are unable to care for themselves because of chronic illness or disability is a relatively recent response to this societal need in the United States. The magnitude of the need has increased with two phenomena: the decline of the multigenerational family unit and the extension of the average life span. While there are a wide variety of causes for the loss of individuals' functional autonomy, consideration of the issues in this case may be aided by identifying four groups of people in need of long-term care: (1) younger persons disabled from injuries sustained in accidents; (2) persons suffering from terminal illnesses; (3) elderly persons who simply "have no place to go"; and (4) elderly persons who are suffering long-term effects from a health crisis, such as a stroke, and who may be expected to recover a fully self-functional status.

Providing appropriate care for these groups and other kinds of patients in a nursing home facility necessarily involves the interplay of multiple forces in the public and private sectors of our social order.

These forces have produced an extraordinarily complex circuitry of laws and regulations functioning under the canopy of the federal legislation known as the Medicaid and Medicare Acts. The Medicare Act establishes a national program of health care for elderly persons who have eligibility under the Social Security system. It is a part of the old age pension plan. Medicaid is an effort by the national government to aid state governments in providing for the welfare of the needy disabled.

The evidentiary record also supports a general finding that all is not well in the nation's nursing homes and that the enormous expenditures of public funds and the earnest efforts of public officials and public employees have not produced an equivalent return in benefits. That failure of expectations has produced frustration and anger among those who are aware of the realities of life in some nursing homes which provide so little service that they could be characterized as orphanages for the aged. A natural reaction to such frustration and anger is to try to find fault by focusing on one actor in the scenario. In this case, the spotlight is on the Secretary of HHS. Simply stated, the plaintiffs' contention is that Medicaid recipients in nursing homes in Colorado are not receiving adequate care because the Secretary has failed to force the state of Colorado to use an appropriate patient care management system to insure the delivery of adequate care.

More specifically, the plaintiffs ask this court to determine that the Medicaid Act and its implementing regulations require that the Secretary of HHS develop and cause all states participating in the Medicaid Program "to implement a patient care focused system of survey/certification enforcement which actually insures as a condition of federal and state reimbursement for such services that Medicaid beneficiaries residing in skilled and intermediate care nursing homes are continuously furnished their entitlements to the appropriate high quality rehabilitative, nursing, psychosocial and mental care necessary to permit them to attain and retain their capabilities for independence and self-care." The plaintiffs further seek a finding that the Secretary has violated the Medicaid Act by failing to develop and implement such a system. To remedy that failure, this court is asked to order that the Secretary of HHS be enjoined and mandated to develop a nursing home enforcement system consistent with the purposes of the Medicaid Act and the Secretary's duty under that Act.

The Medicaid Act

Deciding whether this court has a remedial role in this difficult social problem requires an analysis of the expressed intent of the United States Congress to determine whether the Secretary's asserted duty actually exists. That is not an easy assignment. The Justices of the Supreme Court of the United States have, themselves, lamented the complexity of the Social Security Act in Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981).

Title XIX of the Social Security Act, commonly known as the Medicaid Act and codified at 42 U.S.C. § 1396-1396n, provides funding to enable each state to furnish "necessary medical services" for families with certain dependent children and for aged, blind, or disabled individuals "whose income and resources are insufficient to meet the costs" of those services. 42 U.S.C. § 1396. The payments are made to those states which have submitted, and had approved by the Secretary, state plans for medical assistance meeting all of the requirements set forth in 42 U.S.C. § 1396a(a). Colorado submitted and obtained approval of its plan and thereby became entitled to quarterly payments from appropriated federal funds as reimbursement for prescribed portions of the expenditures made for medical assistance to eligible recipients and certain administrative costs.

The core of the plaintiffs' claim for relief against the Secretary is that the statutory requirements concerning the content of state plans create a correlative entitlement for Medicaid recipients to quality care, and that the Secretary has an enforcement obligation to insure compliance with the approved state plan.

Medicaid is not a program for the federal government to provide medical services. It is a system for federal funding of state plans to furnish health care to needy persons through agreements with private and public persons and institutions capable of providing such services. Harris v. McRae, 448 U.S. 297., 308-09 (1980). To be approved by the Secretary, a state plan must conform to extensive specific requirements set forth in 42 U.S.C. § 1396a(a). That section requires the participating state to designate a "single State agency" to administer or supervise administration of the plan. 42 U.S.C. § 1396a(a)(5). A separate state agency--either the state health agency or other appropriate state medical agency--must be made responsible for establishing and maintaining health standards for the institutions providing care, id. § 1396a(a)(9), and the state plan must include descriptions of the standards and methods the state will use to assure that medical or remedial care services provided to the recipients of medical assistance "are of high quality." Id. § 1396a(a)(22).

Sections 1396a(a)(26) and (31) set out specific provisions which a state plan must include, concerning, respectively, skilled nursing facilities and intermediate care facilities. The plan must provide for "a regular program of medical review . . . of each patient's need for skilled nursing facility care . . . , a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility;" id. § 1396a(a)(26)(A), and for inspection by medical review teams of:

> (i) the care being provided in such nursing facilities . . . to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities . . . to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities . . . , (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities . . . , and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services . . . .

Id. § 1396a(a)(26)(B)(i)-(iv). With respect to intermediate care facilities, § 1396a(a)(31) requires that the state plan provide for independent professional review of identical aspects of the care being provided in those facilities.

Section 1396a(a)(28) requires the state plan to provide that any skilled nursing facilities receiving payments under the plan must comply with all the requirements contained in 42 U.S.C. § 1395x(j), which defines "skilled nursing facility" for purposes of the Medicare Act. Section 1395x(j) sets out numerous specific requirements which must be met by skilled nursing facilities in order to be approved under a state plan for Medicare, including that they must meet "such other conditions relating to the health and safety of individuals who are furnished services in such institution[s] or relating to the physical facilities thereof as the Secretary may find necessary . . ." Id. § 1395x(j)(15).

Under § 1396a(a)(33) a state plan must provide that the appropriate state agency will establish a plan for the review by professional health personnel of the appropriateness and quality of care and services furnished to Medicaid recipients, id. § 1396a(a)(33)(A), and that the appropriate state agency will determine on an ongoing basis whether participating institutions meet the requirements for continued participation in the Medicaid program under the state plan. Id. § 1396a(a) (33)(B). Congress gave the Secretary additional authority to "look behind" the state's determinations of facility compliance, and independently to determine whether institutions meet the requirements for participation in the state Medicaid plan. Id.

Section 1396a(b) provides that the Secretary "shall approve" any plan which fulfills the conditions specified in § 1396a(a), including those described above. The Secretary must reimburse states with approved state plans according to the percentages set out in § 1396b. Section 1396b(g)(3), the "utilization control" provision, mandates that the Secretary reduce the percentage of federal reimbursement if the state fails to show that it has an effective program of control over utilization as defined in that section. If after approving a state plan, the Secretary determines that it has been so changed that it no longer complies with § 1396a(a), or that it complies on paper but not in its actual administration, § 1396c requires him to terminate payments to the state, effectively "disapproving" the plan.

Section 1302 is a general mandate to the Secretary to promulgate rules and regulations necessary to administer the Social Security Act. The regulations under the Medicaid Act are codified primarily at 42 C.F.R. Parts 430-456 (1981). Part 442 contains substantive standards relating to skilled nursing facilities and intermediate care facilities.

From 1972 through 1980 Congress required the Secretary to reimburse the states for all the necessary costs of inspection of long-term care facilities. 42 U.S.C. § 1396b(a)(4). In 1980 Congress reduced the rate of reimbursement to 75% of such costs. Id. § 1396b(a)(2). In conducting surveys of facilities pursuant to 42 U.S.C. § 1396a(a)(33), the states must use federal standards, forms, methods and procedures. 42 C.F.R. § 431.610(f)(1) (1981).

Particularly at issue in this case is HHS' development of the forms required for the states to demonstrate that facilities participating in the Medicaid program under an approved state plan meet the conditions of participation which are contained in the Act. Form SSA-1569 is the form which HHS has required the states to use. It is said to be defective because it is "facility-oriented" rather than "patient-oriented." That characterization is appropriate and HHS has admitted it repeatedly.

Beginning in 1975, HHS has financed studies to change Form SSA-1569 and the reporting procedure, with an emphasis on actual patient care. That process began as the result of a direction from President Nixon following reports which found glaring deficiencies in the services being provided by nursing homes throughout the United States. HHS' outside research and internal efforts culminated in the proposed regulation published in July 1980, which was cited as the reason for the stipulation for a stay of proceedings in this litigation, discussed supra at 6. That proposed regulation was withdrawn by the Secretary and, during the trial of this matter, evidence was presented that HHS' policy may change in a direction opposite to that advocated by the plaintiffs: toward more self-regulation within the nursing home industry, and greater flexibility in reporting on compliance with federally mandated standards contained in approved state plans.

The Plaintiffs' Claims

It is clear from the evidence in this case that it is feasible for the Secretary to require the use of a patient care management system which would control the assessment of patient needs, facilitate the development of an appropriate patient care plan, provide the mechanism for monitoring the delivery of care by the facility itself and by the state review teams, give SSA the means for validating the state reports, and probably improve the quality of health care services provided for all Medicaid recipients. The question then, is not whether such a system is possible or feasible, or whether it is desirable. The issue before this court is whether the failure to introduce and require the use of such a system is a violation of a statutory duty. The answer is no.

The Medicaid Act does not provide a substantive standard for the medical care to be provided under a state plan.

Under 42 U.S.C. § 1396a(a)(9)(A) the responsibility for establishing and maintaining health standards for provider institutions is given to the state health agency, and under § 1396a(a)(22)(A) it is the state which determines the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plans. Under subsection (D) the state plan must include "other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality." And under § 1396a(a)(33), the inspection of nursing homes for survey and certification purposes is the responsibility of the state survey agency under contract with the state agency which administers the state Medicaid plan. In Colorado, the state agency designated to administer the plan is the Colorado Department of Social Services, pursuant to the Colorado Medical Assistance Act, C.R.S. 1973 § 26-4-104, and the designated state survey agency is the Colorado Department of Health.

The plaintiffs have placed particular emphasis on the "look behind" provision in § 1396a(a)(33)(B) which authorizes the Secretary to reject a survey certification performed by the state agency and to substitute the Secretary's own independent and binding determination. That is nothing more than permitted authority to intervene for the purpose of protecting the public funds used to reimburse the state.

As an independent basis for the claimed federal enforcement duty, the plaintiffs point to several rulemaking provisions of the Medicaid Act. Section 1302 is a general mandate to the Secretary to make and publish such rules and regulations "as may be necessary" to the administation of the entire Social Security Act. Absent a specific substantive duty under some other provision of the Social Security Act,

§ 1302 does not impose any rulemaking duty on the Secretary. Section 1396a(a)(33)(A) provides that the state plan for medical inspection and review should be "consistent with regulations prescribed by the Secretary." Even if this provision, coupled with § 1302, requires the Secretary to promulgate regulations regarding survey and certification by the designated state survey agency, the Secretary has complied with that mandate by enacting detailed regulations which set forth state plan requirements, standards, procedures, and conditions for obtaining federal funding in state Medicaid programs. 42 C.F.R. Parts 430-456 (1981).

The plaintiffs have advanced the argument that § 135 of the Tax Equity and Fiscal Responsibility Act of 1982, Pub.L. No. 97-248, 96 Stat. 324, is a Congressional direction to the Secretary. I disagree. That section simply imposes a six-month moratorium on changes in certain regulations, including regulations relating to Medicaid certification and requirements for skilled nursing facilities and intermediate care facilities. It gives no indication of Congressional intent regarding the Secretary's duties under the Medicaid Act.

The structure of the Medicaid Act is strikingly similar to the Developmentally Disabled Assistance and Bill of Rights Act, considered by the Supreme Court in Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981), and to the Education for All Handicapped Children Act of 1975, considered by the Supreme Court in Hendrick Hudson Central School District v. Rowley, 102 S.Ct. 3034 (1982). In both of those decisions, the Court was quite explicit in cautioning that in interpreting such "federal-state cooperative programs" the courts must not impose duties beyond those clearly indicated in the legislation. Specifically, the fact that Congress has acted to encourage the states to adopt programs for the improvement of the lives of disadvantaged persons is not the equivalent to a statutory right to a particular level of improvement.

In sum, the plaintiffs' position is a distortion of the statutory scheme of the Medicaid Act. The primary planner and the initial actor in this welfare program is the state. The national government, acting through the Secretary, provides financial assistance for the provision of services under the state plan and for its administration. The federal enforcement mechanism lies in the reduction of the amount of payments or termination of payments through a disapproval of a plan which no longer is meeting the statutory requirements for participation. Accordingly, even if it is assumed that the members of the plaintiff class have some statutory entitlement to a certain standard of "quality care," and that there has been a denial of that entitlement, the enforcement remedy could not be a writ of mandamus against the Secretary to impose additional requirements on the state. The limit of the mandamus remedy would be an order for the Secretary to terminate all payments by a disapproval of a plan gone awry. That is not the relief sought in this case.

The plaintiffs also have asserted that the residents of nursing homes have a constitutional right to the care necessary to prevent "their pre-existing self-care skills from deteriorating because of their confinement in a nursing home." The language of Justice Blackmum in a concurring opinion in Youngberg v. Romeo, 102 S.Ct. 2452 (1982), is urged in support of this contention. There may be merit to that claim, but it is not the Secretary of HHS who has confined these patients. Accordingly, he is not the proper defendant. This constitutional claim is not appropriately made against the Secretary, or the United States.

In considering the claims in this case, it is important to remember the traditional role of the respective governments in health services. It is the state which determines the qualifications for the licensing of the persons and facilities permitted to participate in the delivery of such services. In Colorado, there is extensive regulation of long-term care facilities and of the various professionals who play a role in long-term health care delivery.

The Colorado Department of Health is responsible for the licensing of hospitals, including nursing care facilities and intermediate care facilities. C.R.S. 1973 § 25-3-101. The department has the authority to adopt rules and regulations setting substantive standards for license applicants, as well as the authority to revoke or suspend a license if the institution has failed to meet statutory requirements and to comply with the rules and regulations of the department. Id. § 25-3-103. In addition to the general provision for summary suspension of a license where the licensing agency has reason to believe that the public health or welfare is endangered, id. § 24-4-104(4), there is a special receivership mechanism to be used in the revocation or suspension of licenses of nursing care facilities and intermediate care facilities, which permits patients to remain at the institution on a temporary basis, and which automatically grants the receiver a new license and certifies the receiver for Medicaid participation. Id. § 25-3-108(1), (7).

A separate state statute, with an express legislative purpose of providing "a measure of protection to the aged and handicapped residents of nursing homes in this state," regulates nursing home administrators. Id. tit. 12, art. 39. That article creates a board of examiners of nursing home administrators which is responsible for the licensure of those administrators and for the development and enforcement of standards "designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators." Id. § 12-39-105(1)(a). Section 12-39-105(4) grants the board of examiners of nursing home administrators the authority to make rules and otherwise to take steps to enable it to comply with 42 U.S.C. § 1396g; that section of the Medicaid Act sets out the requirements of a state program for licensing of nursing home administrators, which is a required feature of an approved state Medicaid plan, under 42 U.S.C. § 1396a(a)(29).

In addition to direct state regulation of nursing homes and skilled nursing facilities and of nursing home administrators, the state plays a critical role in the licensing and regulation of the various professions which take part in the delivery of health care through those institutions. See C.R.S. 1973 tit. 12, art. 36 (Colorado Medical Practice Act); id. art. 38 (Nurse Practice Act, regulating practical nurses and registered nurses); id. art. 22 (regulating the practice of pharmacy); id. art. 41 (Physical Therapy Practice Act of 1979); id. art. 42 (regulating psychiatric technicians); and id. art. 43 (regulating psychologists).

These state statutes, and their implementing rules and regulations, provide the means for the state to develop and enforce standards of long-term care independently of the federal government. The Medicaid Act in no way limits the power of the states to impose licensing requirements on facilities and individual health care administrators and practitioners which exceed the requirements under the Act. Indeed, evidence was presented that several states have taken this step. Of course, independent state enforcement of long-term care quality generally requires an additional commitment of state resources, over and above that provided by the federal government for survey/certification under 42 U.S.C. § 1396a(a)(33), since the states are not reimbursed for costs incurred in inspecting facilities for compliance with state standards only. 42 C.F.R. 431.610(h)(2) (1981). See Comment - A Critical Evaluation of the Federal Role in Nursing Home Quality Enforcement, 51 U.Colo.L.Rev. 607, 616-17 n. 79, 629 n. 126 (1980).

Nothing in the Medicaid Act supersedes the state function of licensure. Indeed, 42 U.S.C. § 1396g requires the state to enact a program for the licensing of nursing home administrators, including the development and enforcement of licensing standards. The cancellation of provider agreements and the de-licensure of nursing homes are the primary sanctions for failures to deliver adequate care to patients in nursing homes. The federal government's enforcement mechanism is simply to pay or to withhold funds from the state. While that power to withhold funds may be the leverage for the exercise of the kind of control which the Colorado plaintiffs would yield, the Secretary's refusal to assert such control is not a refusal to perform a statutory duty.

During the trial of this case, it became clear that Colorado officials understand that the state can cause improvement in the conditions in the nursing homes which the state licenses and regulates. It is also apparent that what is lacking is the resolve to dedicate the necessary resources to this task. It would appear easier to seek a declaration of subservience to the national government to avoid the expenditure of state funds, as well as the responsibility for lack of enforcement. In short, to substitute feudalism for federalism.

In essence, the plaintiffs are asking this court to transform Medicaid into a national health care program. To grant the mandamus remedy requested would be to rewrite the statute. If the Secretary were to exercise the degree of control which the plaintiffs request, there would be a substantial effect on the physician-oriented system of medical care which currently exists in the United States, including in facilities participating in the Medicaid program. Essentially, the system would become nationalized in that both funding and delivery would become the responsibility of the federal government. That is far from the intent of the Congress as disclosed in the statute as originally written and as amended.

Based on the evidence presented at trial and on my analysis of the Medicaid Act, I hold that the Secretary's failure to introduce and require the use of a patient care management system of the sort advocated by the plaintiffs is not a violation of his statutory duties under the Act. Therefore, the plaintiffs' claims against the federal defendant must be dismissed. Insofar as the plaintiffs seek mandamus relief, those claims are dismissed for lack of subject matter jurisdiction, since if there is no duty that is appropriately enforced through mandamus relief, then the court lacks jurisdiction under 28 U.S.C. § 1361. Carpet, Linoleum & Resilient Tile Layers Local 419 v. Brown, 656 F.2d 564, 567 (10th Cir. 1981). The plaintiffs' claims for relief pursuant to the Administrative Procedure Act, 5 U.S.C. §§ 701-706, are dismissed on the merits. The absence in the Medicaid Act of substantive standards for the medical care to be provided under state plans, Congress' recognition of the states' responsibility for setting such standards under their plans, and the discretion vested in the Secretary under the Act, compel the conclusion that the Secretary's implementation of the survey/certification requirement has not been arbitrary, capricious or an abuse of his discretion. Because the plaintiffs have failed to state a claim against the Secretary for violation of the class' constitutional rights, the § 1983 claim must be dismissed also.

It is important to recognize that in this opinion there is no determination with respect to the responsibility of the State of Colorado, Colorado State Department of Health, the Colorado Department of Social Services, and the individual nursing homes that are defendants in this case. All that has been decided is that neither the members of the plaintiff class nor the state plaintiffs in intervention have proved any recognized claims for relief against the federal defendant. The Secretary is entitled to the entry of a judgment of dismissal and there is no just reason for delay in making that judgment final, thereby permitting an immediate appeal under Rule 54(b) of the Federal Rules of Civil Procedure.

The extensive evidence presented in this case and the earnest arguments of counsel for the plaintiffs deserve some additional comment. There is a manifest need for improvement in the conditions of nursing homes and the care which is provided to welfare patients who are housed in them. The desire to alleviate human suffering is a compelling human impulse which easily can generate a Dionysian response. It is perhaps easier to seek redress in the authoritarianism of a court than to ask for change from the politically accountable branches of government at both the state and national levels. It is my considered judgment that to provide the requested remedies would be an abuse of this court's authority and an abridgment of the constitutional restrictions on the separation of powers among the branches of government.

Accordingly, considering the foregoing to be the findings of fact and conclusions of law, it is

ORDERED, that the claims of the plaintiffs and plaintiffs in intervention against the Secretary of Health and Human Services are dismissed, judgment shall enter in favor of the defendant Secretary of Health and Human Services, and that the defendant is entitled to the recovery of costs as against the plaintiffs in intervention from the time of the filing of the complaint in intervention. No costs are awarded against the plaintiff class. Additionally, there being no just reason for delay, pursuant to Rule 54(b) of the Federal Rules of Civil Procedure, the Clerk shall forthwith enter judgment in accordance with this memorandum opinion and order.

Dated: February 8, 1983

BY THE COURT:

Richard P. Matsch

Richard P. Matsch, Judge

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

Nos. 83 1422
83 1446

MICHAEL PATRICK SMITH, et al.,

Appellants,

vs.

MARGARET HECKLER, et al.,

Defendants-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT
COURT FOR THE DISTRICT OF COLORADO

APPELLANTS' OPENING BRIEF

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I. ISSUES PRESENTED FOR REVIEW

Did the district court err in ruling that the:

A. Secretary of Health and Human Services has no legal duty to establish a patient care focused system of survey/certification which is actually capable of ensuring that Medicaid beneficiaries residing in nursing homes are furnished the appropriate high quality care to which they are entitled under the Medicaid Act and implementing regulations?

B. Current survey/certification system imposed upon the states by the Secretary of Health and Human Services fulfills the statutory purpose, meets the requirements of the Medicaid Act and is neither arbitrary, capricious, nor an abuse of his discretion?

C. Court lacks the power to order the Secretary of Health and Human Services to implement a patient care focused system of survey/certification which is capable of ensuring that Medicaid beneficiaries are furnished the appropriate high quality care to which they are entitled under the Medicaid Act and implementing regulations?

II. STATEMENT OF THE CASE

A. Nature of the Case.

This appeal is from the Memorandum Opinion and Order granting a judgment of dismissal by the U.S. District Court for the District of Colorado entered on February 8, 1983. Appellants are individual Medicaid certified, low income elderly and disabled persons, representing themselves and all other Colorado Medicaid certified nursing home residents, and the State of Colorado. They challenge the legality under the Medicaid Act of the "quality of care enforcement system" (survey certification system) for nursing homes promulgated by the Secretary of Health and Human Services (hereinafter referred to as the Secretary or HHS). Appellants contend that the Secretary has breached her duty under the Medicaid Act by promulgating and requiring all states participating in the Medicaid program to utilize a survey/certification system so defective that it is a major cause of the substandard care being provided Medicaid residents of nursing homes throughout the country.

The trial court found that the Secretary's survey/certification system is defective and that the quality of care in Medicaid certified nursing homes is almost nonexistent.

Nevertheless, it held that the Secretary of HHS's failure to introduce and require the use of a patient care focused survey/certification system for Medicaid certified nursing homes which is actually capable of ensuring that Medicaid beneficiaries are furnished appropriate high quality care is not a violation of her statutory duties. Therefore, the district court dismissed appellants' claims against the Secretary. Appellants contend that they are deprived of their statutory rights by this dismissal.

B. Course of the Proceedings Below.

This suit was originally filed in May 1975 against what was then known as Heritage House Nursing Home in Lakewood, Colorado, the U.S. Department of Health, Education and Welfare (now known as the Department of Health and Human Services), and the Colorado Departments of Health and Social Services.

In response to the complaint, the government defendants launched a vigorous briefing and motion campaign contending that the court lacked jurisdiction over the subject matter and seeking summary judgment. In response to these motions and to affidavits from Medicaid certified nursing home residents detailing abysmal care, the district court attempted to conduct a state-wide survey of the actual care being delivered in Colorado nursing homes prefatory to ruling on these motions. Although the State of Colorado cooperated with the court's approach, the Secretary of HHS continually objected to the survey and, despite substantial efforts of volunteer participants under the leadership of the then Dean of the Denver University Law School, the survey was never conducted.

On March 16, 1978, the court ruled that it had jurisdiction over all plaintiffs' claims. Also on March 16, 1978, the State of Colorado requested leave of the court to file a complaint-in- intervention. In support of this motion, the State of Colorado asserted that it agreed with the plaintiffs that the challenged federal survey/certification system which it is forced to administer in Colorado is a "national disgrace" and incapable of ensuring that Medicaid recipients receive the appropriate, high quality care to which they are entitled under the Medicaid Act and regulations. In April 1978, plaintiffs filed an amended complaint and the state filed a complaint-in-intervention.

On April 14, 1978 the district court certified the case as a Rule 23(b)(2) class action covering all Medicaid recipients residing in skilled or intermediate care facilities in the State of Colorado.

From 1978 to 1980, all parties to the action engaged in extensive documentary and depositional discovery. On July 14, 1980, the Secretary of HHS proposed new regulations, including a patient care management system, which if finalized, would have achieved the goals of this litigation. In response to this publication, a stay in these proceedings was agreed to by the parties and approved by the district court.

In January 1981, the proposed rules which formed the basis for the stay were withdrawn by the Secretary of HHS. In response to this withdrawal of the regulations, the stay in these proceedings was lifted and the claims against the Secretary were tried over a twelve day period, from May 17, 1982 until June 4, 1982. The claims against the nursing home defendants were not involved in that trial and thus are not subject to this appeal.

A final judgment of the district court dismissing the claims against the Secretary was rendered on February 8, 1983. This appeal from that judgment was taken in accordance with all applicable rules.

C. Statement of Relevant Facts.

1. Large investments of public funding in Medicaid certified nursing homes yield only substandard nursing home care because of the Secretary of HHS's failure to develop an effective nursing home quality of care enforcement system.

In fiscal year 1983, the federal government will expend over $7.6 billion in nursing home reimbursement for approximately 1.5 million elderly, blind and disabled persons who qualify for Medicaid reimbursement. In addition, the federal government will spend over $40.8 million to reimburse states to perform the federally mandated survey/certifications of Medicaid certified nursing homes which are at issue in this case. In Colorado alone, over $69 million of federal funding will be used in fiscal year 1983 to cover the costs of nursing home care for Medicaid beneficiaries and to reimburse the state for the federal portion of its survey/certification costs.

As Medicaid is a federal-state cooperative program, these federal expenditures are matched by state dollars. Currently, Colorado anticipates expending in fiscal year 1983 $67 million in Medicaid nursing home reimbursement and to cover its share of the survey/certification costs.

Despite this large investment of federal and state dollars, the frail, elderly, blind and disabled Medicaid recipients are simply not getting the care they need and to which they are entitled. As the district court specifically stated:

> The evidentiary record...supports a general finding that all is not well in the nation's nursing homes and that the enormous expenditures of public funds and the earnest efforts of public officials and public employees have not produced an equivalent return in benefits. That failure of expectations has produced frustration and anger among those who are aware of the realities of life in some nursing homes which provide so little service that they could be characterized as orphanages for the aged...

In Re Estate of Smith v. O'Halloran, 557 F. Supp. 289, 293 (D. Colo. 1983), (Appendix pp. 8-9) (emphasis added)

The court further found that:

> There is a manifest need for improvement in the conditions of nursing homes and the care which is provided to welfare recipients who are housed in them.

Id. at p. 299 (Appendix p. 22)

One of the major factors causing this pervasive system of poor care in Medicaid certified nursing homes, and the sole factor at issue in this case, is the Secretary of HHS's failure to develop and enforce a patient care focused survey/certification inspection system which is actually capable of ensuring that Medicaid recipients are furnished appropriate high quality care to permit them to attain or retain their capabilities for independence and self care. As the district court specifically found, the current survey/certification system mandated by the Secretary is "defective because it is 'facility- oriented' rather than 'patient-oriented'." As the court further pointed out, "HHS has repeatedly admitted" the defect. Id. at p. 295 (Appendix p. 13).

2. Congressional, State and HHS studies have long recognized the failure of the Secretary's current survey/certification system.

The Secretary's current survey/certification system was first promulgated in 1974. At least five years before this defective "facility oriented" system was established by regulation, the Department of HHS itself published a number of patient care assessment systems, the results of nearly twenty years of government funded research. In 1973, HHS published the Patient Classification for Long Term Care: Users Manual which the Department proclaimed is a patient care assessment system tested for validity and reliability and capable of use in evaluating the care actually delivered to patients. As Drs. Densen, Jones, Caldwell, Katz and Robbins testified at trial, the Department could have readily implemented this patient care focused system in 1973. Drs. Densen and Jones are the directors and principal researchers at the Harvard Center for Community Health and Medical Care and the principal authors of the patient classificiation system. (Tr. Ex. Nos. 17; Jones 5/26/82 p.m. Tr., pp. 28, 29, Appendix, pp. 24 - 25; Densen 5/26/82 a.m. Tr., pp. 54 - 56, Appendix, pp. 26 - 28; Katz 5/26/82 p.m. Tr., pp. 76, 77, Appendix, pp. 29 - 30; Caldwell 5/19/82 a.m. Tr., pp. 46-48, Appendix, pp. 31 - 33; Robbins 5/18/82 a.m. Tr., pp. 21-24, Appendix, pp. 34 - 37).

Disregarding the findings and patient care assessment systems developed by its own researchers, HHS, nevertheless, promulgated the current survey/certification system which systematically ignores patients and focuses solely on facilities.

The same year this system was promulgated by HHS, the Senate Subcommittee on Long Term Care of the Senate Special Commmittee on Aging issued its report, Nursing Home Care in the United States: Failure in Public Policy, (Tr. Ex. No. 18) This report, based on hearings in twenty-five cities, concluded that the federal Medicaid survey/certification system was a failure because it requires the states to focus on what is called "paper review" of nursing facilities' theoretical capabilities for providing care rather than on whether the care is actually being provided. It further found that 50% of the nation's Medicaid and Medicare nursing homes were and are providing substandard care with one or more life threatening conditions. (Tr. Ex. No. 18, p. 208, Appendix, pp. 38 - 39)

Congress highlighted the harm resulting from this failure in enforcement through committee hearings during the next few years. From 1974 to 1976, the Senate Special Committee on Aging, under Chairman Frank Moss, issued nine studies on most aspects of the nation's nursing home industry, the results of fifteen years of hearings on these issues. (Tr. Ex. No. 18) These reports disclose scandalous profiteering by nursing home operators at the expense of patient care: overuse of medications, improper and inadequate care provided by untrained personnel, unsanitary conditions, poor food, fire and safety problems, lack of dental, eye care and podiatry, failure of physicians to serve elderly residents, reprisals against those who complain, and discrimination against minorities.

Partially in response to these Moss Committee reports, President Nixon and HHS Secretary Weinberger launched the "long term care facility improvement campaign." The purposes of this campaign were to train the federal delegate nursing home inspectors and redesign the federal Medicaid/Medicare nursing home quality standards and enforcement process to focus on whether residents were obtaining needed care, rather than on facilities' theoretical capability of providing it.

According to HHS, the survey conducted as part of the long term care improvement campaign was the most extensive and scientifically valid study of nursing home conditions ever undertaken. (Tr. Ex. No. 37, pp. 5 - 8, Appendix pp. 40 - 44) Almost 300 facilities were surveyed nationwide. Enough facilities were reviewed, according to HHS, to provide a reliable picture of conditions in all skilled nursing facilities in this country. Rather than using its current survey/certification system and conducting the usual paper review of facility structure, HHS surveyors performed actual patient assessments using the appraisal instrument developed by the authors of the Patient Care Classification System: Users Manual. The January 8, 1975 report of the nursing home long term care survey team summarizes some of the basic findings of this survey:

> There was far more evidence of low and poor quality care being provided than of high quality care...
>
> In regard to rehabilitative services, there was a concensus that it was "invisible." Occupational therapists or physical therapists were nonexistent or were going to the nursing homes after working hours. Speech therapy service was almost totally ignored by the facilities and simply not provided. There was very little evidence of patient assessment to determine progress being made by the patient and whether the rehabilitative regimen outlined in the plan of care needed modification...Rehabilitative services is rated poor, yet this exceedingly important service must be improved in order to obtain high quality care...
>
> The lack of meeting the psychosocial needs of the patients was the most distressing and consistent deficiency noted by the survey teams. Staff was inadequately trained to meet the psychosocial needs of the patients.

(Tr. Ex. No. 32, pp. 3 - 5, Appendix pp. 45 - 48)

A Fact Sheet on the long term care facility improvement study issued in August 1975 reported the following national findings:

> WHO ARE THE PATIENTS?
>
> They are old: the median age is 82, and 50% are over 80. 73% are women; 90% are caucasian. 87% are single (mostly widowed). 52% completed grade school; 16% graduated mostly from high school; 4% finished college...
>
> They cannot bathe without difficulty. 60% need some help, and 33% more cannot bathe themselves at all. 72% require help in dressing. 34% need some help in eating, and 16% must be fed by others. 45% must be helped in using the toilet; 29% cannot use it at all. 50% experience some degree of incontinence — from occasional to total. 87% are not fully ambulatory; 9% suffer pressure sores because of reduced ability to move in bed.

> Impaired vision is suffered by 68%;... 32% more have some degree of speech impairment. 92% are missing some or all natural teeth, and 38% lack compensating restorations or dentures. 54% show some confusion as to time, place, or their own identify (27% occasionally and 27% continuously). 41% display inappropriate behavior — typically wandering or disruptiveness...
>
> Of the patients who need physical therapy 31% receive it; 11% of those needing occupational therapy get it, and 11% who could benefit from speech therapy get it.
>
> For 33% of patients undergoing therapy, there is no written therapy plan. And 84% of patient records do not contain baseline data for use in determining therapy needs. (Emphasis added.)

(Tr. Ex. No. 43, pp. 1 - 4, Appendix pp. 49 - 52)

This national pattern of substandard care in Medicaid certified nursing homes is equally characteristic of care provided in Colorado Medicaid certified nursing homes. Two Colorado nurse surveyers, who between them have twenty-four years of experience in surveying nursing homes and who have surveyed literally thousands of nursing homes, testified at trial that 80% of the approximately 18,000 patients living in Colorado nursing homes are receiving only custodial care. Dr. VanderLeest, one of the surveyors, characterized the care as "bed and board and occasional wash up." (See, VanderLeest 5/21/82 p.m., Tr., pp. 53, 56, 57, 105; Toohey 5/22/82 p.m. Tr., pp. 62, 63, 101, 110, Appendix, pp. 53 - 60).

Another Colorado witness, Dr. Barbara Harley, a Harvard trained specialist in health care evaluation and geriatric medicine, summarized for the court the 14,000 medical review assessments of Colorado Medicaid recipients that she supervised between 1977 and 1979. She testified from her records that 65% of Medicaid recipients were not being offered rehabilitative care consistent with the Medicaid Act and implementing regulations. She further testified, based on her study, that on average, only 20-25% of the services required to be delivered to nursing home residents under the Medicaid Act and regulations were actually provided to them. (See, Harley 5/17/82 a.m. Tr. pp. 66-68, 103; 5/17/82 p.m. Tr. pp. 10-12, Appendix pp. 61 - 67). Finally, all of these witnesses as well as state surveyors from Kentucky and Wisconsin and appellants' principal experts characterized the Secretary's current system of survey/certification as one of the major causes for this pattern of inappropriate and inadequate care because it is incapable of determining the care actually being delivered. (See VanderLeest 5/21/82 a.m. Tr., pp. 66, 86, 87, 92; Toohey 5/22/82 p.m. Tr., pp. 66, 76; Ware 5/20/82 a.m. Tr., pp. 88, 89, 97, 98; Jones 5/26/82 p.m. Tr., pp. 16, 17, 18; Katz 5/26/82 p.m. Tr., pp. 64, 65, 66; Densen 5/26/82 a.m. Tr. pp. 46, 47; Appendix pp. 68 - 85). The evidence regarding gruesome care received by individual Colorado nursing home residents-appellants was admitted by stipulation in summary form. See Tr. Ex. Nos. 300 and 310.

The Colorado witnesses' condemnation of the Secretary's survey/certification system is consistent with the Department of HHS's own critique of its system. In its July 1975 Long Term Care Facility Improvement Study: Introductory Report, the Department fully acknowledged that the federal enforcement system is a failure in ensuring that Medicaid recipients receive the care which they need and to which they are entitled. HHS admitted that its system can only measure the theoretical capacity of a facility to render care but cannot evaluate the quality of care actually being rendered. The report concludes that the present federal enforcement system must be changed:

> There must be a shift from the facility's capability to provide services to the patients and residents to assessing the services actually being provided to them.

(Tr. Ex. No. 37, p. 15, Appendix, pp. 86 - 87).

A few months later, in a nationally disseminated press release announcing HHS's intent to reform its own system, then HHS Undersecretary Marjorie Lynch stated:

> Federal regulations focus on facilities not patients. A facility's capacity to deliver a given level of care has been more important than whether the patients actually receive this care or, in fact, whether the care even meets minimum requirements. The time has come to put the patient first.

(Tr. Ex. No. 64, pp. 1 - 2, Appendix, pp. 88 - 89)

In April 1976, Dr. Faye Abdellah, the Assistant Surgeon General, then in charge of the Office of Nursing Home Affairs of HHS, acknowledged:

> The current situation in survey and certification can be characterized as one of mounting cost and regulation which does not accomplish the basic intent of certification — the assurance that a facility provides quality care to the individual patient.

(Tr. Ex. No. 69, p. 1, Appendix, p. 90)

According to Dr. Abdellah, the poor quality of care in nursing homes is:

> fundamentally... traceable to the fact that federal regulations, the method of reimbursement, and the survey/certification process focus on the institutional framework within which care is provided rather than on patients.

(Tr. Ex. No. 59, p. 2, Appendix, pp. 91 - 92)

The New York Moreland Act Commission on Nursing Homes and Residential Facilities, established to investigate widespread patient abuse and neglect in nursing homes, reported in 1976 that of the 541 items which must be completed by state survey and certification inspection teams utilizing the present federally mandated form 1569, (Tr. Ex No. 90, Appendix, pp. 93 - 127) only 30 of the items are even marginally related to patient care or might require any patient observation:

> The survey inspections concentrate on the written word and can be passed largely by "paper compliance." Thus of the 526 identifiable items in the 68-page federal skilled nursing home survey inspection report, the Commission's review indicates that 290 items can be answered by the surveyor exclusively with reference to written plans, policies and records. In the Commission's view, only 30 of the 526 items might require direct observation of patients.

(Tr. Ex. No. 48, pp. 10 -11, Appendix, pp. 128 - 130)

Even as late as July 1980, HHS admitted in the Federal Register that, in the conduct of federal survey/certification inspections:

> State surveyors rely almost totally on records, documentation and written policies in the assessment of care provided.

(Tr. Ex. No. 222, Fed. Reg. p. 47368, Appendix pp. 131 - 132)

3. HHS proposes reform of its survey/certification system between 1976-1980.

Between 1976 and 1980, HHS set out to reform the federal survey/certification system. HHS through the Office of Nursing Home Affairs engaged in a very ambitious, multi-million dollar national effort to develop and field test a new resident focused, systematic process of nursing home care appraisal.

By February 1978, HHS had successfully conducted field feasibility studies of a patient assessment and care evaluation system (PACE) in 140 facilities in 19 states from all 10 federal regions. In a briefing book for House and Senate appropriation hearings, HHS summarized the results of these field studies:

> Nursing home personnel themselves can carry out PACE. The services provided and the progress of an individual can be measured. The PACE instrument can serve as an effective care planning and evaluation tool for nursing home personnel. Those responsible for surveying the facility by using the PACE system can determine whether the facility is in compliance with the federal regulations.

(Tr. Ex. No. 147, Appendix, pp. 133 - 134)

Six months later, Secretary Califano submitted to Congress a report entitled, The PACE Program for Long Term Care. This document glowingly described the system it had developed and successfully demonstrated as follows:

> PACE is systematic, continuous, objective, practical and effective. It is a base for measuring the patient status, the care given and the outcomes of care. PACE, therefore, provides an excellent opportunity to change the survey and certification process from one of paper compliance to one in which determination of compliance is on the basis of outcomes of care and thus the quality of care.

(Tr. Ex. No. 121, p. 2, Appendix, pp. 135 - 136)

In July 1978 testimony before the Subcommittee on Federal Spending Practices and Open Government, Helen Smits, then the Director of the Standards and Quality Bureau of HCFA, admitted that HHS had received many criticisms that the survey/certification system promulgated in 1974 is inappropriately focused and indicated that a notice of proposed rulemaking aimed at correcting the system would be published in early 1979. (See Tr. Ex. No. 181, pp. 405 - 406, Appendix pp. 137 - 139) Subsequently, proposed regulations incorporating the PACE system were drafted by January 1979 and sent out to consumer and industry representatives for comment.

In July 1979, HHS published the Long Term Health Care, Minimum Data Set. This tandem document to the PACE system provides a common set of assessment data and definitions and is fundamental to the Secretary's mandating the PACE process at the facility level and to the revamping of the survey certification process to focus on actual care delivery. (Tr. Ex. No. 205)

In July 1980, HHS finally published in the Federal Register proposed regulations which included a patient care management system. In this notice of proposed rulemaking, the Department also promised to develop new survey forms and interpretative guidelines incorporating the common data and definitions mentioned above which are focused on the care actually being delivered to patients rather than on mere paper compliance. (Tr. Ex. No. 222, Fed. Reg. pp. 47376 - 47377, Appendix, pp. 140 - 142) In response to this July 1980 notice of proposed rulemaking, appellants and HHS petitioned the district court for a stay of proceedings based upon the following Stipulation:

> The Federal defendant represents to the Court that on July 14, 1980 the Department of Health and Human Services (HHS) issued proposed revisions to the regulations governing the Conditions of Participation for Skilled Nursing and Intermediate Care Facilities that participate in the Medicaid/Medicare programs. HHS believes that these revisions will, if adopted, place more emphasis on the quality of care and services actually received by nursing home patients. If adopted in final form, these revisions would require all skilled nursing and intermediate care facilities to implement a patient care management system, which includes a comprehensive patient assessment, as a condition of participation in the Medicaid/Medicare programs. The regulations would also require skilled nursing and intermediate care facilities that participate in these progams to use, as part of this assessment, a form that is certified by the State Survey Agency to contain at least minimum core data requirements specified by the Health Care Financing Administration (HCFA). In addition, the preamble to the proposed revisions states that "HCFA will

specify more detailed minimum data requirements and common definitions" which facilities will also be required to use in their assessment forms.

The regulations would also require "(t)he facility's patient care management activities (to) ensure the provision of quality care, and be designed to permit achievement and maintenance of optimal functional status and independence" for its nursing home residents. The preamble to the proposed regulations also indicates that subsequent to the final publication of the revisions, the Department will develop "new survey forms and interpretive guidelines with a view toward pointing the surveyor's attention toward more outcome, patient focused evaluation of compliance with the regulations." The Federal defendant's counsel have been informed by Thomas Morford and Janice Caldwell, who are officials of the Health Standards Quality Bureau (HSQB), the bureau of HCFA that is responsible for developing the regulations revisions and the new survey forms and interpretive guidelines for surveyors, that it is their intention and the intention of the HSQB that if the proposed regulations are published in final form, the survey forms and interpretive survey guidelines will take effect on the same date that the revised guidelines will take effect.

Discussion between Federal defendant's counsel and the same officials named in the paragraph directly above indicates that it is the present intent of these officials that if the regulations are adopted substantially in final form as proposed, the guidelines and survey forms would require state survey/certification inspectors — as a major part of their survey inspection to determine whether a facility satisfies the conditions on Patient Care Services (483.20-483.29 of the proposed revisions) — to examine a randomly selected representative sample of patients to validate the adequacy and appropriateness of the facility's comprehensive assessment process, and its care and discharge plans with respect to such persons, and to determine by directly reviewing the actual conditions and needs of the residents assessed whether, in fact, the facility is providing needed and required care of an acceptable quality to its patients. In addition, discussion between these same persons indicates that it is also their present intent that the guidelines and forms would require state survey/certification inspectors to examine a randomly selected representative sample of patients to determine whether the condition on Patients' Rights (483.50 of the proposed revisions) is met. Since States are required under present regulations at 42 C.F.R. 431.610(f)(1) to use all "federal standards and the forms, methods and procedures that the Administrator (of HCFA) designates... to determine provider eligibility and certification under Medicaid," these guidelines and forms will be considered by HCFA to be mandatory upon the States.

Based upon this Stipulation, a stay was ordered by the district court on August 7, 1980.

Although particular provisions of the proposed regulations did generate some controversy, the patient care management system regulations was universally acclaimed. In the words of Carolyn Davis, Administrator of HCFA, to Secretary Schweiker:

> ...PCMS has been overwhelmingly supported by the public and... it represents a major step towards the promotion of quality care.

(Tr. Ex. No. 253, Appendix pp. 143 - 144). See also testimony at trial of the current director of HHS Division of Long Term Care, Penny St. Hillaire, admitting that the Department can and should implement this reform. (St. Hillaire 6/2/82 p.m. Tr. pp. 71-72, 106; Appendix pp. 145 - 147)

4. The Secretary reneges on the promised reform of the survey/certification system.

In January 1981, the June 1980 regulations setting forth the patient care management condition were withdrawn by executive order. No reason for this withdrawal was given except that the Department had decided not to issue the regulation until it had an opportunity to evaluate further all comments received, and the economic impact of the regulation as a whole. (Tr. Ex. No. 222, Fed. Reg. p. 7408, Appendix p. 148)

Since then the Secretary of HHS has refused to reissue the patient care management condition regulation. Instead, the Secretary has attempted to deregulate the nursing home industry. See Tr. Ex. Nos. 303 A and B. Such deregulation efforts, however, have been halted by a Congressionally imposed moratorium included in the Tax Equity and Fiscal Responsibility Act, Public law 97-276.

The current situation, then, is as it was when this lawsuit was commenced nearly eight years ago. The Secretary continues to mandate that all states participating in the Medicaid program utilize her facility oriented survey/certification system, which the Department has repeatedly admitted is defective and which the evidence of record has shown to be useless. All states, including the State of Colorado, despite attempts to secure waivers from this requirement, are forced to utilize this federally mandated system. (See Robbins 5/18/82 a.m. Tr., pp. 41, 46, Appendix, pp. 149 - 150; Tr. Ex. No. 125, 136, 186, Appendix, pp. 151 - 172; Fryback 5/21/82 a.m. Tr. p. 22, Appendix p. 173) And so appellants are virtually in the same position as they were eight years ago despite the finding of the district court that:

> ...It is feasible for the Secretary to require the use of a patient care management system which would control the assessment of patient needs, facilitate the development of an appropriate patient care plan, provide the mechanism for monitoring the delivery of care by the facility itself and by the state review teams, give SSA the means of validating the state reports, and probably improve the quality of health care services provided for all Medicaid recipients. The question then is not whether such a system is possible or feasible or whether it is desirable.

In Re the Estate of Smith, supra, at 295 (Appendix p. 14) The issue before this court, then, in the words of the district court is:

> ...whether the failure to introduce and require the use of such a (patient care focused survey/certification) system is a violation of a (Secretary's) statutory duty.

Id. at p. 295 (Appendix p. 14)

III. ARGUMENT

A. THE DISTRICT COURT ERRED IN HOLDING THAT SECRETARY OF HEALTH AND HUMAN SERVICES HAS NO LEGAL DUTY TO ESTABLISH A PATIENT CARE FOCUSED SYSTEM OF ENFORCEMENT WHICH IS ACTUALLY CAPABLE OF ENSURING THAT MEDICAID BENEFICIARIES RESIDING IN NURSING HOMES ARE FURNISHED THE APPROPRIATE HIGH QUALITY CARE TO WHICH THEY ARE ENTITLED UNDER THE MEDICAID ACT AND REGULATIONS.

1. The Medicaid statute, regulations and administrative construction of the Act evidence a clear duty on the part of the Secretary to promulgate regulations to govern the review of the appropriateness and quality of care and services furnished Medicaid beneficiaries residing in nursing homes.

Medicaid is a federal-state cooperative program, under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., to provide medical assistance to families with dependent children, and aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C. 1396. Skilled nursing home care is one of the mandated services which must be provided to eligible persons by states which opt to participate in the Medicaid program. 42 U.S.C. 1396d(a)(4)(A) Intermediate nursing home care is an optional service which states may provide. 42 U.S.C. 1396d(a)(15). States are not required to participate in Medicaid or to provide optional services under Medicaid, but if they do, they must comply with all requirements imposed both by the Act itself and regulations promulgated by the Secretary of HHS. See 42 U.S.C. 1396a; Schweiker v. Gray Panthers, 453 U.S. 34, 37, (1981).

The Secretary of HHS is the general managing partner in this federal state cooperative medical assistance program. It is she who must:

> ...Make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which (the Secretary) is charged under the Act.

42 U.S.C. 1302. (Emphasis added)

As Judge Matsch himself found in his August 2, 1983 Memorandum Opinion in Pulido, et al. v. Heckler, (Civil Action No. 82-M-1143), "This section (42 U.S.C. 1302) imposes a duty upon the Secretary to establish regulations required for the efficient administration of the program of benefits". (Slip Memorandum Opinion, at p. 6).

Under the Medicaid Act, the Secretary must also approve each state's plan for medical assistance as well as any modifications to the plan proposed by the state before any federal money is dispersed to the states. 42 U.S.C. 1396a. She must continuously monitor the implementation of each state's Medicaid plan. If she finds any part of the plan out of compliance with the federal Medicaid Act and implementing regulations, she must withhold the federal payment to the state for at least those parts of the plan out of compliance. 42 U.S.C. 1396c.

In the Medicaid statute, Congress specifically provides that the content of the state plans is to be guided by regulations promulgated by the Secretary. Each state's Medicaid plan must provide:

> a. Such methods of administration... *as are found by the Secretary* to be necessary for the *proper and efficient operation* of the plan... 42 U.S.C. 1396a(a)(4)(A);
>
> b. That the state agency will make such reports, in such forms and containing such information, *as the Secretary may from time-to-time require*, and comply with such *provisions as the Secretary may from time-to-time find necessary* to assure the correctness and verification of such reports... 42 U.S.C. 1396a(a)(6);
>
> c. For a regular program of independent professional review including medical evaluation of each patient's needs for intermediate care and a written plan of service prior to admission for authorization of benefits in an intermediate care facility *as determined under regulation of the Secretary*... 42 U.S.C. 1396a(a)(31); and
>
> d. That the state health agency, or other appropriate state medical agency, shall be responsible for establishing a plan, *consistent with regulations prescribed by the Secretary*, for the review by *appropriate professional health* personnel of the *appropriateness and quality of care and services furnished to recipients of medical assistance under the plan*... 42 U.S.C. 1396a(a)(33)(A). (Emphasis added).

These statutory requirements for the development of the state's medical assistance plan make clear that, while the states are empowered to develop and implement medical assistance plans under the Medicaid Act, it is up to the Secretary to issue regulations setting out federal requirements for the state plans and to monitor compliance of state plans with federal law.

Finally, the Medicaid Act allows the Secretary even greater responsibility for skilled and intermediate nursing home care then for some of the other medical services provided under the Medicaid program. The Act specifically empowers the Secretary to:

> Make *independent* and *binding* determinations concerning the extent to which individual institutions and agencies meet the requirements for participation (in the Medicaid Program) if the Secretary has any cause to question the adequacy of the state action.

42 U.S.C. 1396a(a)(33)(B). (Emphasis added) The Medicaid statute further provides at 42 U.S.C. 1396i(c)(1) that the Secretary may "look behind" state determinations regarding the compliance of particular nursing home providers with the federal Medicaid requirements and cancel approval of any particular facility she finds out of compliance. In effect, Congress has empowered her to overule state administrative decisions regarding the certification of nursing home providers reimbursed with Medicaid funds.

Throughout the past eighteen years since Congress first enacted the Medicaid Act, the various Secretaries of Health and Human Services have consistently interpreted these statutory provisions of the Medicaid Act as requiring comprehensive federal regulation to guide state Medicaid programs and strong enforcement of these federal guidelines. 42 C.F.R. Parts 405.1101 - 1137 and 430-456 contain over 500 pages of state Medicaid plan requirements, standards, procedures, and conditions for obtaining federal funding established by the Secretary of Health and Human Services. The various Secretaries have over the years enforced these federal requirements by disapproving state Medicaid plans and/or denying federal reimbursement for state Medicaid programs found to be out of compliance with the federal statute and regulations.

This administrative interpretation that the Medicaid Act requires the Secretary to assert strong federal control over the Medicaid program is particularly evident in the area of nursing home care. Since at least 1974, the various Secretaries of HHS have consistently asserted their ultimate supervisory responsibility of nursing home care reimbursed with Medicaid funds.

In 1974, the Secretary promulgated detailed federal conditions of participation for nursing homes seeking to participate in the Medicaid program. 42 C.F.R. 405.1101 - 1137. In the same year, the Secretary developed an enforcement system including standards, forms, methods and procedures for surveying and certifying nursing homes, and mandated that all states participating in Medicaid thereafter use this system in determining nursing home provider eligibility and certification under Medicaid. 42 C.F.R. 431.610(f)(1).

In promulgating this federally mandated nursing home survey/certification system, the Secretary cited 42 U.S.C. 1396a(a)(33) as the legal basis for the regulation. Despite substantial revisions in Medicaid regulations over the past three years, this assertion of legal responsibility was retained in the federal regulation at 42 C.F.R. 431.610(a)(2). Thus the Secretary of HHS explicitly recognizes, through the current regulations of her own department, her statutory duty to prescribe an enforcement system to govern the review by appropriate health personnel of the appropriateness and quality of care and services furnished to Medicaid recipients who reside in nursing homes. 42 U.S.C. 1396a(a)(33)(A). This statutory basis for the Secretary's mandating that states use all federal forms, methods and procedures in conducting survey/certification was expressly recognized by the district court. In Re the Estate of Smith, supra, at 295 (Appendix p. 13)

The admissions of the Department from 1974 through 1982 further support appellants' position regarding the Secretary's duty.

HHS's Regional Director's Long Term Care Manual published in 1974 describes the duties arising out of the Medicaid portion of the Social Security Act as follows:

> The Secretary of the Department of Health, Education, and Welfare has stated that there is no higher priority in the Department than achieving a high level of care in a safe environment for older Americans...

The manual further states that under Medicaid, because the federal-state line of responsibility is from DHEW to the single state agency, the single state agency makes the actual decision with respect to provider participation in accordance with federal requirements and the scope and purposes of the Medicaid program. (Tr. Ex. No. 23, Appendix pp. 174 - 176)

Health Care Financing Administrator, Robert Derzen, was even more direct when he stated, at the "New Directions for Skilled Nursing and Intermediate Care Facilities" public hearings in 1978, that the primary responsibility of his agency is:

> to see that the beneficiaries of our Medicare and Medicaid programs — the aged and the poor — have access to high quality care. We need to develop regulations that are sensible, and that focus on the outcome of care as well as the process thereof, and that can be effectively enforced.

(Tr. Ex. No. 171 at p. 6, Appendix, pp. 177 - 178)

Equally clear was Edward L. Kelly, Acting Director, Office of Standards and Certification for HHS, in a 1978 memo to Regional Directors of Health Standards and Quality:

> The federal government is responsible through the Medicare/Medicaid programs for the health and safety of patients as well as the quality of the services provided.

(Tr. Ex. No. 185 at p. 1, Appendix, pp. 179 - 180)

In 1980, Mr. Kelly reiterated this interpretation of HHS's duty when he said flatly:

> We are responsible for ensuring that patients receive quality care in a safe setting. (Emphasis added.)

(Tr. Ex. No. 233, p. 4, Appendix, pp. 181 - 182)

In a 1979 Report of the Task Force on Survey and Certification Problems in Region I presented to the Administrator of HCFA, the allocation of duties between the federal government and states is set out as follows:

> The clear intent of Congress in the laws governing nursing homes is that the state is responsible for seeing that standards are met and that the federal government is responsible for ensuring that the states carry out their responsibilities.
>
> A major goal of HCFA's standards and certification program is to ensure that our sick and needy beneficiaries who require nursing home care receive the high quality care to which they are entitled.

(Tr. Ex. No. 206, Appendix, pp. 183 - 184)

Finally, at the trial of this case, the federal government's principal witnesses and former officials in charge of survey/certification admitted that the federal government has a duty to promulgate a survey/certification system capable of ensuring that Medicaid recipients receive the high quality of care required under the Medicaid Act. (See Caldwell 5/19/82 a.m. Tr., p. 9, Appendix p. 185; Szucs 6/1/82 a.m. Tr., pp. 12-14, Appendix pp. 186 - 188; St. Hillaire 6/2/82 p.m. Tr., p. 83, Appendix p. 189; Morford 5/27/82 a.m. Tr., pp. 9, 12 - 13, Appendix pp. 190 - 192). See Tr. Ex. No. 309, p. 3, Appendix pp. 193 - 195 in which HHS informs Congress in a 1982 appropriation request that the purpose of survey/certification is to ensure that patients obtain an "optimum quality of care."

2. The purpose and specific statutory requirements of the Medicaid Act as interpreted by the Secretary require that she promulgate and enforce a patient care focused system of survey/certification which is capable of ensuring that Medicaid beneficiaries residing in nursing homes are furnished appropriate high quality care.

The specific purpose of the Medicaid Act is to assist the states to furnish:

> 1. Medical assistance on behalf of families with dependent children and of aged, blind, or permanently or totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary services...

and to provide:

> 2. Rehabilitation and other services to help such families and individuals attain or retain capability for independence and self care...

42 U.S.C. 1396 (Emphasis added)

This statutory purpose has been interpreted by at least one court to mean that Medicaid beneficiaries have a:

> right to good health and full physical and mental development, which Congress and the Executive have sought to preserve by providing the medical services described in the Medicaid legislation and further delineated in 45 C.F.R. 250.30(a)(6) and other regulations promulgated by HEW.

Yanez v. Jones, 361 F. Supp. 701, 706 (N.D. Utah 1973)

Congress expresses the rights of Medicaid beneficiaries, however, not only in the purpose clause of the statute, but also in other substantive provisions of the Medicaid Act. For example, Congress in 42 U.S.C. 1396d(a)(1)-(18) outlines the full range of medical services for which federal funding participation is available. In addition, Congress at 42 U.S.C. 1396a(a)(10) specifies those services which must be provided Medicaid beneficiaries. According to this provision, all states opting to participate in the Medicaid program must provide to all who qualify under the federal Act, at a minimum, the following services:

1. Inpatient hospital services (42 U.S.C. 1396d(a)(1);
2. Outpatient hospital and rural health clinic services (42 U.S.C. 1396d(a)(2);
3. Laboratory and x-ray services (42 U.S.C. 1396d(a)(3);
4. Skilled nursing facilities services (42 U.S.C. 1396d(a)(4);
5. Physician's services (42 U.S.C. 1396d(a)(5);
6. Nurse-midwife services (42 U.S.C. 1396d(a)(5); and
7. Transportation to medical services (42 U.S.C.a(a)(4)(A)

States may opt to provide twelve additional services including intermediate nursing home care. 42 U.S.C. 1396d(a)(15), but if they choose to do so, the service must be provided in conformity with the standards of the Medicaid Act and implementing regulations.

Further, the Medicaid Act specifically provides that the medical services provided to Medicaid recipients must be "appropriate" and "of high quality." 42 U.S.C. 1396a(a)(33)(A), 42 U.S.C. 1396a(a)(22)(D). With regard to nursing home care, the statute specifically provides that the services must "meet the current health needs and promote the maximum physical wellbeing of patients receiving care in such homes." 42 U.S.C. 1396a(a)(26). Care and services must also be provided in a manner consistent with the best interests of the recipient. 42 U.S.C. 1396a(a)(19).

These statutory requirements, in the context of nursing home care, have been further defined and interpreted by the Secretary of Health and Human Services at 42 C.F.R. 405.1101 - 1137. A sampling of the specific standards of care defined by the Secretary in these regulations are as follows:

1. The facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. (42 C.F.R. 405.1124(c);

> 2. In addition to rehabilitative nursing, the skilled nursing facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech therapy and audiology, and occupational therapy) *as needed by patients to improve and maintain functioning*... (42 C.F.R. 405.1126;
>
> 3. ...*The medically related social and emotional needs of the patient are identified and service is provided to meet them*, either by qualified staff of the facility, or by referral, based on established procedures, to appropriate social agencies. (42 C.F.R. 405.1130(a);
>
> 4. The skilled nursing facility provides for an activities program, *appropriate to the needs and interests of each patient to encourage self-care, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning*. (42 C.F.R. 405.1131) (Emphasis added)

In both the statutory provisions and in the Secretary's interpretive regulations, the entitlement of Medicaid beneficiaries to be furnished appropriate care and service sufficient to meet their needs and to enable them to attain or retain their capability for independence and self-care is definite and clear. Therefore, this case, contrary to the district court's view, is not governed by the U.S. Supreme Court's decision in *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

The statutory duty of the Secretary of HHS must be interpreted so as to be consistent with both the purpose of the Medicaid Act and the clear statutory requirements. As argued earlier, the Secretary of HHS has a clear statutory duty under 42 U.S.C. 1302 and 42 U.S.C. 1396a(a)(33)(A) to prescribe a system of nursing home enforcement to judge "the appropriateness and quality of care and services furnished to Medicaid recipients." It is not enough for the Secretary to simply issue regulations. To fulfill her statutory duty, consistent with the purposes of the Act and the statutory requirements outlined above, the Secretary must prescribe and enforce a nursing home survey/certification system which is actually capable of judging and ensuring that Medicaid beneficiaries are furnished the appropriate high quality care and services necessary to meet their needs and to help them attain or retain their capability for independence and self-care.

This interpretation of the Secretary's duty under 42 U.S.C. 1302, 1396, and 1396a(a)(33)(A) is further required for the proper implementation of the "look behind" authority granted the Secretary at 42 U.S.C. 1396i(c)(1). As described earlier, this "look behind" authority empowers the Secretary to override the decisions of state Medicaid survey/certification agencies when the Secretary finds that particular nursing homes do not meet the standards of care for skilled nursing facilities outlined in 42 U.S.C. 1395x(j)(1)-(15) and for intermediate care facilities set out at 42 U.S.C. 1396d(c). These requirements include in the case of a skilled nursing facility

> such other conditions relating to the health and safety of individuals who are furnished services in such institutions... as the Secretary may find necessary...

42 U.S.C. 1395x(j)(15), and in the case of an intermediate care facility

> such conditions as prescribed by the Secretary as (she) finds appropriate for the proper provision of care...

42 U.S.C. 1396d(c) (Emphasis added)

As indicated above, the Secretary has prescribed these additional conditions in the regulations found at 42 C.F.R. 1101-1137. For the Secretary to fairly determine a facility's compliance with these regulations, the Secretary must utilize a survey/certification system which focuses on the care or lack of care actually provided to the Medicaid beneficiaries residing in the specific nursing homes under review and which is capable of measuring compliance with the standards outlined in the federal regulations. Mere paper compliance is not enough.

B. THE DISTRICT COURT ERRED IN HOLDING THAT THE CURRENT SURVEY/CERTIFICATION SYSTEM IMPOSED UPON THE STATES BY THE SECRETARY OF HEALTH AND HUMAN SERVICES MEETS THE REQUIREMENTS OF THE MEDICAID ACT AND IS NEITHER ARBITRARY, CAPRICIOUS NOR AN ABUSE OF HER DISCRETION.

1. The Secretary of Health and Human Services' current survey/certification system is inconsistent with both the purpose and clear statutory requirements of the Medicaid Act.

The Secretary of Health and Human Services has developed and implemented a uniform national system of nursing home survey/certification. This system consists of SSA form 1569, the Medicaid/Medicare facility report forms; HCFA form 2567, form for the statement of deficiencies and plan of correction; the post recertification revisit report; orientation training manual and basic course manual contained in Tr. Ex. No. 90 as well as the interpretive guidelines contained in the record as Tr. Ex. No. 38.

Appellants contend that these federally mandated forms, methods and procedures violate both the purpose and the clear statutory requirements of the Medicaid Act in that the system is only capable of judging the theoretical capacity of a nursing home to deliver care and is not capable of measuring the quality of care actually delivered to Medicaid beneficiaries.

The evidence presented at trial established beyond any doubt that, at its core, the survey/certification system which HHS mandates all states to utilize is inherently incapable of assuring that nursing home residents actually receive their benefits. The system's principle flaw is that it utterly fails to focus in any rationale way on the residents themselves, their needs and the care they are receiving. States must review nearly everything imaginable: the number of dishtowels, the number of nurses aides, orderlies, the sprinker systems, the facilities, menus, written policies regarding residents' Medicaid entitlements, the written plans of care that are supposed to exist for patients, and 530 other items. Confirmation of this point is found in the reports of state nursing home commissions, public and industry statements. See, 1976 Illinois Report (Tr. Ex. No. 91); AFL-CIO Report (Tr. Ex. No. 117); Robbins Affidavit (Tr. Ex. No. 153); New York Moreland Act Commission Report (Tr. Ex. No. 48); Ohio Legislative Report (Tr. Ex. No. 170); American Health Care Association 1981 Statement (Tr. Ex. No. 238); and the 1981 Statement of the National Council of Health Centers (Tr. Ex. No. 244). The fatally flawed premise of the survey system under attack in this case is that by determining whether these things are in place, the theoretical capability of each facility to give the required care that each resident's needs may in some way be determined. If the capability is found to be present, an enormous, entirely indefensible and illegal leap of faith is made. It is concluded that the care is actually being delivered. This conclusion is drawn in the absence of any real data being gathered about the care residents are actually receiving in each surveyed facility.

The Secretary's survey/certification system which depends upon this unwarranted inference from theoretical capability to the fact that actual care is being delivered is similar in methodology to the cost reimbursement system struck down by the Fifth Circuit Court of Appeals in Alabama Nursing Home Association v. Harris, 617 F.2d 388 (1980). The Medicaid provision under review in the Alabama case required that states reimburse nursing homes on a cost related basis according to "cost finding methods approved and verified by the Secretary." 42 U.S.C. 1396a(a)(13)(E)

The Alabama cost reimbursement system, which the Secretary approved pursuant to this statutory requirement, reimbursed nursing homes based upon the assumption that the projected billing rate of the median cost facility in each nursing home class would reasonably approximate a reasonable reimbursement for the costs actually incurred by particular nursing homes. Neither Alabama nor the Secretary did any study of the costs of actual individual nursing homes.

In striking down the Alabama cost reimbursement system which the Secretary had approved, the Fifth Circuit Court of Appeals stated that:

> The Secretary (of HEW), in carrying out his statutory function of reviewing, approving, and verifying the states' methodologies, has the responsibility to seek to assure that the methodologies will in fact result in reasonable cost related reimbursement.

617 F.2d at p. 393

The Fifth Circuit further found that the Secretary failed to perform his statutory duty by failing:

1. To establish specific criteria or standards by which both state and federal officials could determine the meaning of crucial statutory and regulatory terms;

2. To formulate criteria by which to judge the reasonableness of the classes utilized in the proposed reimbursement methodology; and

3. To require a system which would look at actual cost incurred by individual nursing homes rather than relying upon theoretical cost assumptions.

Surely, nursing home residents deserve no less than this in terms of evaluation of care, i.e., a realistically based means of assessment. The Secretary's duty in this case is almost identical to that which gave rise to the Alabama Nursing Home Association v. Harris case. Here the Secretary is obligated to approve and enforce compliance of state plans and nursing homes with the standards of care set out in the Act and in the implementing regulations. The Secretary is also required to verify state determinations that care is actually being furnished to Medicaid recipients residing in nursing homes. The question before this Court, then, is whether the Secretary is fulfilling her statutory duty by assuming, despite contrary evidence, that facilities which can demonstrate paper compliance with standards are actually providing quality care to nursing homes residents. Appellants contend that the Secretary, by continuing to mandate a system which relies entirely upon this assumption, is failing in her statutory duty.

HHS itself has repeatedly admitted this failure. The Departmental documents from 1974 to the present which were admitted at trial clearly demonstrate that the various Secretaries and their designees have long recognized that the Department's survey/certification system has failed to fulfill this duty. See Section II,C, supra. A much more comprehensive chronological listing of the departmental admissions on this point are contained in the record of this case in a 343 page document entitled, Summary of Admitted Documents. (Appendix, pp. 205 - 547) The consistent theme of these admissions is well summarized by two official departmental publications. The Long Term Care Facility Improvement Study: Introductory Report, published in 1975 states:

> The underlying premise of the Titles XVIII and XIX survey form is that by measuring the capacity of a facility to provide an acceptable quality of care, the federal government may assume that the facility is in fact providing care of that quality. In short, the XVIII and XIX forms measure capacity and infer quality...

> Present survey items reflect the regulations which, in turn, are based on a hospital model and should be redesigned to assess patient care in long-term care facilities. There must be a shift from the facility's capability to provide services to the patients and residents to assessing the services actually being provided to them.

Key

> The survey findings document that paper compliance alone provides insufficient evidence to show that quality care is being provided to patients in a safe environment...

(Tr. Ex. No. 37, pp. 3, 14, 15, Appendix, pp. 196 - 199)

The Secretary's 1980 regulatory anaylsis of the proposed regulations reiterates these 1975 findings and announces the Department's proposed solution to this problem:

> A general conclusion has emerged from various studies conducted during the past few years relating to nursing homes: the need to improve the quality of care delivered in long-term care facilities.
> In 1974, the Department announced a long-term care facility improvement campaign. The overall goal of the campaign was to upgrade nursing home services... One specific finding (of that campaign) was that the survey and certification process focuses on the institutional framework within which care is provided rather than on the patient. The study zeroed in on patient care and recommended that a systematic assessment of individual patient's needs should be the first step toward planning for appropriate care...
>
> In developing the proposed requirements, we were cognizant of the results of studies which over the years demonstrated the need for a systematic method of assessing the needs of the long-term care patient. Results from the Long-Term Care Facility Improvement Campaign, for example, disclosed that, of 3,000 patients surveyed, 1,437 (47.9%) needed physical therapy. Many impairments (loss of sight, hearing, amputation, etc.) were simply not reported. Results from the PACE I feasibility study disclosed that an assessment instrument could not only assure that such patient needs were identified but could serve as an effective care planning and evaluation tool for nursing home personnel. Additionally, surveyers could not objectively determine from the instrument the quality of care being provided.
>
> Our proposal (the patient care management system regulation) represents an attempt to break this unusual chain of events.

(Tr. Ex. No. 220, pp. 3, 7, 8, 24, Appendix, pp. 200 - 204)

Unfortunately, the Secretary, after publishing these proposed regulations, withdrew them and has never implemented this long-promised reform of the survey/certification system. As there have been no substantial changes in the federally mandated survey/certification procedures since they were first promulgated in 1974, Secretary Weinberger's statement first uttered in 1975 is as true today as in 1975:

> ...Present survey/certification procedures do not measure the quality of care actually delivered to patients. They measure only the capability of the home to deliver a given level of care. The two are not the same — and obviously the more realistic measure is the care actually being delivered. (Tr. Ex. No. 33)

As the Secretary's current survey/certification system is incapable of measuring whether or not appropriate care is actually being furnished Medicaid beneficiaries in nursing homes, it is inconsistent with the purposes and the specific statutory requirements of the Medicaid Act. Therefore, the Secretary is simply failing to perform her statutory duty.

2. The Secretary of HHS's eight year refusal to implement a patient care focused system of survey/certification is arbitrary, capricious and an abuse of her discretion.

It is undisputed that the Secretary of HHS has developed and enforced the use of a uniform national system of nursing home survey/certification. In promulgating this survey/certification system in 1974, the Secretary made no explanation at all why the "facility theoretical capacity for care" focus was chosen over the "actual care delivered" basis for enforcement of the rights of Medicaid beneficiaries residing in nursing homes. The Secretary's action cannot be upheld "merely because findings might have been made and considerations disclosed which would justify (the Department's enforcement system)...," SEC v. Chenery Corporation, 318 U.S. 80, 94 (1943). The statement of basis and purpose of the regulation "must be sufficiently detailed and informative to allow a searching judicial scrutiny of how and why the regulations were actually adopted." Amoco Oil Company v. Environmental Protection Agency, 501 F.2d 722, 739 (D.C. Cir. 1974). In short, the court must be satisfied that the Secretary's decision to base the nursing home enforcement system solely on the facility's theoretical capacity to provide quality care "was based on a consideration of the relevant factors" and that there has not been a "clear error of judgment." Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971). See also Home Box Office, Inc. v. FCC, 567 F.2d 9, 34-36 (D.C. Cir. 1976), cert. den. 434 U.S. 829 (1977); National Association of Food Chains, Inc. v. ICC, 535 F.2d 1308, 1318 (D.C. Cir. 1976); Diplomat Lakewood, Inc. v. Harris, 613 F.2d 1009, 1024 (D.C. Cir. 1979); and National Welfare Rights Organization v. Mathews, 533 F.2d 637 (D.C. Cir. 1976).

Not only did the Secretary fail in 1974 to cite any evidence in the record to support adoption of the "theoretical capacity" model of enforcement, but also, in making this choice, the Secretary ignored without explanation the findings of the Department's own research. As indicated in Section II-C of this Brief, HHS had been funding patient focused assessment systems since the early 1960's. The documentary and testimonial evidence at trial clearly proved that this research had demonstrated the feasibility of implementing an effective resident assessment system in the early 1970's. For example, in 1970, four years before the Secretary promulgated the system of enforcement challenged in this lawsuit, the Department received the final report, Development of a Patient Classification System, (Tr. Ex. No. 8) produced by the Harvard Center for Community Health and Medical Care pursuant to an HHS contract. This report outlines the findings of researchers from Harvard, John Hopkins, Case Western Reserve and Syracuse Universities regarding a patient focused classification and enforcement system. Three years later in 1973, but still a year before the Secretary promulgated the current conditions of participation regulations, the Department itself published Patient Classification for Long Term Care: User's Manual which definitively established the basis for a resident focused assessment of care system. As indicated in Section II-C supra, this patient classification system had been tested and found to be reliable, feasible and useful in assessing the quality of care provided to nursing home residents. (Tr. Ex. No. 18).

Nevertheless, the Secretary failed to incorporate this patient assessment classification system as part of the enforcement system promulgated in 1974 despite the fact that many experts in such assessments specifically argued at the time that any effective enforcement system must focus on care actually delivered and must be premised upon a common data base and a systematic patient classification system. See Tr. Ex. Nos. 25 and 26. Despite these warnings, the Secretary of HHS published the surveyer's manual and forms without incorporating a patient focused assessment system. The Secretary's action, in promulgating the existing survey/certification system, therefore, was arbitrary, capricious and an abuse of authority. Diplomat Lakewood, Inc. v. Harris, supra at 1024.

Seven years later, in July 1980, the Secretary of HHS finally published as a proposed rule the long awaited patient care management system. (Tr. Ex. No. 222, Appendix, pp. 140 - 142) This proposed rule was supported by consumers and the nursing home industry itself. (Tr. Ex. No. 224). Nevertheless, the proposed rule was withdrawn by the Secretary in January 1981 with no explanation given other than the assertion that the Department wished to study the issue further. (Tr. Ex. No. 222, Appendix p. 148) As the United States Supreme Court in Motor Vehicle Manufacturers Association, et al. v. State Farm Mutual Automobile Insurance Co., et al, 51 U.S. L.W. 4953 (June 24, 1983) held:

> An agency changing its course by rescinding a rule is obligated to supply a reasoned analysis for the change...

51 U.S. L.W. at 4956

Given the twenty years of study and the millions of dollars of federal funding dedicated to this issue, the repeated admissions of HHS that its present survey/certification system is defective and that a patient care oriented system is necessary to ensure that nursing home residents receive the care to which they are entitled under the Medicaid Act and implementing regulations, the Secretary of HHS's withdrawal of the rule without a rational explanation is arbitrary, capricious and an abuse of her discretion.

C. THE COURT HAS THE POWER AND DUTY TO REQUIRE THAT THE SECRETARY OF HEALTH AND HUMAN SERVICES PROMULGATE AND ENFORCE A PATIENT CARE FOCUSED SYSTEM OF SURVEY/CERTIFICATION CAPABLE OF ENSURING THAT MEDICAID BENEFICIARIES ARE FURNISHED THE APPROPRIATE HIGH QUALITY CARE TO WHICH THEY ARE ENTITLED UNDER THE MEDICAID ACT AND IMPLEMENTING REGULATIONS.

1. The Separation of Powers Doctrine Requires, Rather than Prevents, the Court's Intervention in this Case.

The District Court has refused to order the Secretary of Health and Human Services to promulgate and enforce a patient care survey/certification system capable of ensuring that Medicaid beneficiaries are furnished the appropriate high quality care to which they are entitled under the Medicaid Act and implementing regulations on grounds that such action:

> would be an abuse of this court's authority and an abridgement of the constitutional restriction on the separation of powers among the branches of government.

In Re the Estate of Smith, supra at 299 (Appendix p. 22) The District Court, in its opinion, provided no rationale for this conclusory assertion.

Appellants assert, on the contrary, that the separation of powers doctrine compels judicial intervention in this case. "It is emphatically the province and duty of the judicial department to say what the law is." Marbury v. Madison, 1 Cranch. 137, 177, 2 L.Ed. 60, 73 (1803); See also, Diamond v. Chakrabarty, 447 U.S. 303 (1980). The principle of separation of powers is not violated by judicial efforts to enforce congressional mandates. Caswell v. Califano, 583 F.2d 9 (1st Cir. 1978).

2. This court is empowered by the Administrative Procedure Act 28 U.S.C. 1361 and 28 U.S.C. 1331 to order the Secretary to fulfill her statutory duty.

Congress has specifically provided for judicial review of administrative agency action such as that at issue in this case in 28 U.S.C. 1361, 28 U.S.C. 1331 and 5 U.S.C.

701-706. This court has specifically ruled that under the Administrative Procedure Act, 5 U.S.C. 701-706,

> There is a basic presumption of judicial review for one suffering legal wrong because of, or adversely affected or agrieved by, agency action. Abbott Laboratories v. Gardner, 387 U.S. 136, 140, 87 S. Ct. 1507, 18 L. Ed.2d 681. The cited exception for discretionary action is a very narrow one, applicable in those rare instances where statutes are drawn in such broad terms that in a given case there is no law to apply. Citizens to Preserve Overton Park v. Volpe, supra; See National Helium Corporation v. Morton, 455 F.2d 650, 655 n. 12 (10th Cir.); Parker v. United States, 448 F.2d 793, 795 (10th Cir.), cert. denied sub nom; Kalbab Industries, v. Parker, 405 U.S. 989, 92 S. Ct. 1255, 31 L. Ed.2d 455.

Sabin v. Butz, 515 F.2d 1061, 1065, (10th Cir. 1975)

In Sabin, the court was asked to review the denial by the Forest Service of a special use permit to allow an independent ski instructor to teach downhill skiing in the White River National Forest. Although recognizing that 16 U.S.C. 497 grants the Secretary of Interior broad authority to issue permits, this court nevertheless found that a decision by the Forest Service to deny this special use permit was subject to judicial review as there was "law in the statute to apply" and the case raised substantial issues as to whether or not the agency action was arbitrary or unlawful. 515 F.2d at 1065.

This court has also agreed to review federal agency administrative actions under 28 U.S.C. 1361 and 28 U.S.C. 1331 on innumerable occasions. Specifically relevant to this case is Carpet, Linoleum and Resilient Tile Layers Local Union No. 419 v. Brown, 656 F.2d 564 (10th Cir. 1981). In the Carpet, Linoleum and Resilient Tile Layers Local 419 case, this court took a broad view of its mandamus and mandatory injunctive power:

> ...It is the court's duty in a mandamus action to 'measure the allegations in the complaint against the statutory and constitutional framework to determine whether the particular official actions complained of fall within the scope of the discretion which Congress accorded the administrators... In other words, even in an area generally left to agency discretion, there may well exist statutory or regulatory standards delimitating the scope or manner in which such discretion can be exercised. In these situations, mandamus will lie when the standards have been ignored or

> violated.' Davis Associates, Inc. v. Secretary, Department of Housing and Urban Development, 498 F.2d 385, 389 (1st Cir. 1974). Also, "if the court's study of the statute and relevant legislative materials caused it to conclude that the defendant official had failed to discharge a duty that Congress intended him to perform, the court should compel performance and thus effectuate the congressional purpose." Byse & Fiocca, 'Section 1361 of the Mandamus and Venue Act of 1962 and "Nonstatutory" Judicial Review of Federal Administrative Action,' 81 Harv. L. Rev. 308, 337 (1967). See also State Highway Commission v. Volpe, 479 F.2d 1099, 1104 n.6 (8th Cir. 1973); Peoples v. Department of Agriculture, 427 F.2d 561, 564 - 65 (D.C. Cir. 1970).
>
> Similar principles govern the district court's jurisdiction to issue the requested mandatory injunction. Such jurisdiction can be based in federal question jurisdiction, 28 U.S.C. 1331. The injunctive remedy itself would be provided by the Administrative Procedure Act, 5 U.S.C. 706(1), which authorizes a court reviewing agency action to "compel agency action unlawfully withheld."
>
> We do not think that alternative or concurrent jurisdiction under both 1361 and 1331 is particularly troublesome. We are mindful of previous statements by this court that '(i)njunctive relief is not authorized under (1361).' McQueary v. Laird, 449 F.2d 608, 611 (10th Cir. 1971). A close reading of McQueary reveals, however, that the court there was speaking only to negative injunctions — injunctions which "restrain the doing of an injurious act." Id. A mandatory injunction such as the one sought here is essentially in the nature of mandamus. Thus, jurisdiction for its issuance can be based on either 1361 or 1331, or both. See Crawford v. Cushman, 531 F.2d 1114, 1126 nn.15, 16 (2d Cir. 1976); Operating Engineers Local 627 v. Arthurs, 355 F. Supp. 7, 13-14 (W.D. Okla.), aff'd, 480 F.2d 603 (10th Cir. 1973).
>
> With these jurisdictional bases, and whether we label the relief sought as mandamus or as mandatory injunction, the issue remaining is whether defendants here have failed to discharge a duty owed to plaintiffs which Congress has directed them to perform.

656 F.2d 566-67.

The Secretary of HHS is not immune from such scrutiny. Several courts have reviewed both regulations promulgated by the Secretary of HHS pursuant to the Medicare and Medicaid statutes as well as her interpretations of her own rules. Johnson's Professional Nursing Home v. Weinberger, 490 F.2d 841 (5th Cir. 1974); Florida v.

Mathews, 526 F.2d 319, 336 (5th Cir. 1976); Springdale Convalescent Center v. Mathews, 545 F.2d 943, 951 (5th Cir. 1977); AMI-CHANCO, Inc. v. U.S., 576 F.2d 320, 326 (U.S. Court of Claims 1978); Blankenship v. Secretary of HEW, 587 F.2d 329 (6th Cir. 1978); Pacific Coast Medical Enterprises v. Harris, 633 F.2d 123 (9th Cir. 1980); Washington Adventists Hospital, Inc. v. Califano, 512 F. Supp. 932 (D. Md. 1981).

The rulemaking authority of the Secretary, like any administrative officer, must be exercised within certain parameters and it is the court's duty to see that these limits are not exceeded. Southland Royalty Co. v. Federal Energy Administration, 512 F. Supp. 436, 446 (N.D. Texas 1980)

> The power of an administrative officer or board to administer a federal statute and to prescribe rules and regulations to that end... is (only) the power to adopt regulations to carry into effect the will of Congress as expressed by the statute. A regulation which does not do this, that operates to create a rule out of harmony with the statute, is a nullity.

Manhattan General Equipment Company v. Commissioner of Internal Revenue, 297 U.S. 129, 134 (1936). See also United States v. Larinoff, 431 U.S. 864, 873 (1977); Ernest v. Hochfelcher, 425 U.S. 185, 213-214 (1976).

If the Secretary's administrative interpretation is found to impede or inhibit Congressional will, either on its face or as applied, it must be struck down. Pacific Coast Medical Enterprises v. Harris, supra, at 132; Diplomat Lakewood, Inc. v. Harris, supra, at 1024. Further, the court may order the Secretary to promulgate new regulations which comply with his duties under the statute and may retain jurisdiction over the matter to ensure compliance with its order. Blankenship v. Secretary of HEW, supra; Alabama Nursing Home Association v. Harris, supra.

In short, the district court as well as this court have broad equitable powers to afford appellants any relief found by this court to be consistent with Congressional purpose. Bell v. Hood, 327 U.S. 678, 684 (1946).

The present case before this court meets these tests for judicial intervention. As argued earlier in this brief, the Secretary of HHS has a clear duty under 42 U.S.C. 1302, 1396 and 1396a(a)(33)(A) to promulgate and enforce a survey/certification system which is actually capable of ensuring that Medicaid beneficiaries residing in nursing homes receive the high quality appropriate care to which they are entitled under the Medicaid Act. Mere paper compliance is not enough. The purpose of the Medicaid Act is to furnish such persons with medical assistance, rehabilitation and other services to help them attain or retain capability for independence and self-care. 42 U.S.C. 1396. The standards of care to be afforded Medicaid beneficiares are equally clear in the statute. Such care must be appropriate, of high quality, and must meet the current health needs and promote the maximum physical well-being of patients receiving care in nursing home institutions. 42 U.S.C. 1396a(a)(33)A), 1396a(a)(22)(D), and 1396a(a)(28).

Even in those areas of the Medicaid Act which accord the Secretary some discretion, i.e., the "look behind" authority contained in 42 U.S.C. 1396i(c)(1), these same statutory provisions provide discernable standards by which the exercise of the Secretary's discretion may be reviewed by the court. See the argument in Section III-A, supra.

Just as the 5th Circuit Court of Appeals in Alabama Nursing Home Association v. Harris, supra, struck down Alabama's cost reimbursement system which the Secretary had approved, and ordered the Secretary to promulgate regulations consistent with the purposes and requirements of the Medicaid Act, this court has the power to intervene in this case and order the Secretary to promulgate a survey/certification system which is patient care focused and capable of ensuring that Medicaid recipients actually receive the appropriate high quality care to which they are entitled.

Appellants respectfully request that this court exercise that authority. The Secretary of HHS has had ample opportunity to reform the survey/certification system and has demonstrated her unwillingness to do so despite the fact that her own department has already researched, developed and field tested the necessary patient care focused system. (Tr. Ex. No. 222). Without this court's intervention, the current defective survey/certification system will remain in effect and the pattern of abuse and neglect of the elderly, blind and disabled persons residing in this country's Medicaid certified nursing homes will continue unabated.

IV. CONCLUSION

The Secretary of HHS has a clear legal duty to promulgate and enforce a patient care focused survey/certification system capable of ensuring that Medicaid beneficiaries residing in nursing homes actually receive the appropriate high quality care to which they are entitled under the Medicaid Act and implementing regulations. The Secretary, by refusing to reform her current defective "facility oriented" survey/certification system has and continues to fail to comply with her statutory duty. As a result, Medicaid beneficiaries residing in nursing homes are deprived of their statutory entitlements under the Medicaid Act to high quality, appropriate care necessary to help them attain or retain their independence and self-care. The District Court erred in its ruling that the Secretary of HHS has no legal duty beyond the mere promulgation of survey/certification regulations and that the court has no authority to order the Secretary to promulgate and enforce a patient care focused survey/certification system consistent with the purpose and requirements of the Medicaid Act. The judgment of dismissal should be reversed and the District Court ordered to fashion a remedy consistent with statutory requirements as outlined in the proposed order which had been previously submitted to the district court at its request, and which is attached hereto and incorporated herein by reference.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLORADO

Civil Action No. 75-M-539

In re the Estate of: MICHAEL PATRICK SMITH *et al.*, Plaintiffs, and PEOPLE OF THE STATE OF COLORADO, *et al.*, Plaintiffs in Intervention, vs. THOMAS J. O'HALLORAN, *et al.*, Defendants.	PROPOSED ORDER

IT IS HEREBY ADJUDGED and DECREED:

~~1. That~~ the Medicaid Act (42 U.S.C. 1396 *et seq*,) and implementing regulations require that the Secretary of Health and Human Services develop and cause all states participating in the Medicaid Program to implement a patient care focused system of survey/certification enforcement which actually insures as a condition of federal and state reimbursement for such services that Medicaid beneficiaries residing in skilled and intermediate care nursing homes are continuously furnished their entitlements to the appropriate high quality rehabilitative, nursing, psychosocial and medical care necessary to permit them to attain and retain their capabilities for independence and self-care;

2. ~~That the~~ Secretary of Health and Human Services has violated the Medicaid Act:

A. By developing, implementing and maintaining a nursing home survey/certification enforcement system which is neither designed nor implemented so as to reasonably and reliably determine in a uniform

ATTACHMENT A

and objective manner the actual care needs of Medicaid residents and whether in fact these needs are being met by the facilities in which they reside. Rather the current enforcement system focuses on and judges the capacity of a nursing home facility to deliver care and erroneously assumes and concludes that a finding that such capacity exists means that required care of an acceptable quality has been or will be delivered to the facility's residents;

B. By proposing an unlawful delegation of his enforcement duty to the Joint Commission on Accreditation of Hospitals, a private agency with no equivalent enforcement powers or orientation; and

C. By proposing to implement a flexible survey cycle permitting some Medicaid nursing homes to be surveyed less frequently than annually based upon the inadequate data concerning each facility's historical compliance with federal laws and regulations which has been generated by the presently misfocused survey/certification system; and

3. That these actions by the Secretary are unlawful in that they are inconsistent with the best interests of the Medicaid recipients and are irrational, arbitrary, capricious and an abuse of the Secretary's discretion.

IT IS THEREFORE ORDERED that the Secretary of Health and Human Services is hereby enjoined and mandated to develop a nursing home enforcement system consistent with the purposes of the Medicaid Act and the Secretary's duty under

42 U.S.C. 1302 and 42 U.S.C. 1396 et seq. and enjoined from promulgating as final regulations the proposed regulations appearing in the May 27, 1982 Federal Register, Vol 47, No. 103 at pp. 23404-23414.

IT IS FURTHER ORDERED that, sixty days from the date of this order, the Secretary shall submit to the court a written plan which shall detail the manner in which and the timetable by which the Secretary will meet his duty to design and cause the states participating in the Medicaid program to implement a system of enforcement which actually ensures that Medicaid beneficiaries residing in nursing homes are continuously furnished the appropriate high quality rehabilitative, nursing, psychosocial and medical care necessary to permit them to attain and retain their capabilities for independence and self care. Such plan shall include at a minimum:

1. A detailed description of the procedures to be managed detail by regulation for use at the skilled nursing and intermediate care facility level which will assure that, upon entrance into the facility and at reasonable intervals thereafter, each Medicaid recipient's needs for rehabilitative, nursing, psychosocial and medical care are comprehensively assessed. The procedures will further assu~~me~~re that an appropriate plan of care based upon these needs is developed and implemented; that each patient's progress under the care plan be continuously assessed and the care plan revised and updated as the needs of the patient change; and

2. A detailed description of revised patient care focused survey/certification forms, methods, interpretive guidelines, and procedures used by the state survey agencies in conducting inspections of Medicaid certified skilled and intermediate nursing care facilities. These forms, methods and procedures will ensure that Medicaid recipients are being accurately assessed, that care is appropriately planned, that needed care of a reasonable quality is actually

provided, that the conditions of residents are continuously re-evaluated and care plans modified and updated as needed, and to determine thereby the effectiveness and quality of the care which has been delivered to individual Medicaid program beneficiaries.

These detailed descriptions as outlined in paragraphs 1 and 2 above shall at a minimum address the following issues:

1. How the Secretary will modify the survey forms, training manuals and interpretive guidelines to incorporate a patient care review focus;

2. How the modified survey/certification report form will collect and report patient specific information from the surveyor's assessments;

3. How state survey staff and facility staff will be trained in the assessment process;

4. How the Secretary will insure that both facilities staff and state surveyors are utilizing appropriate long term care common data and definitions in the patient care management and enforcement inspection processes, and particularly the type of uniform facility assessment instrument the Secretary will mandate or how, in the absence of such mandated form, the Secretary will assure that, at a minimum, facilities utilize long term care common data and definitions as specified by the Secretary in the assessment of each patient;

5. How the Secretary will insure that the assessment of patient care conducted by the state survey agencies will produce a statistically valid appraisal of the care actually delivered by the nursing home facility;

6. The means by which the Secretary will insure that the participation of Medicaid residents in individual care assessments to be performed by state surveyors or their agents as part of the survey/certification process is voluntary and that persons not wishing to be involved are not required to participate;

7. How the Secretary will involve physicians in the survey/certification process when questions of the adequacy of care delivered to Medicaid residents require physician judgment;

8. Which standards, conditions or elements of the present survey certification process should be retained as part of the enforcement system and how such portions of the current system will be integrated with the revised patient care focused survey certification process;

9. How the medical review function mandated by the Medicaid Act will be integrated into or otherwise made efficient and consistent with the new survey/certification process;

10. What guidance the Secretary will give to state survey agencies regarding the implementation of any intermediate sanctions presently permitted by federal law to force compliance with quality of care standards;

11. How the Secretary will implement his authority to authorize flexible survey cycles so as to insure that only those facilities with a demonstrated history of delivering high quality appropriate care to Medicaid recipients are exempted from the annual survey process; and

12. How the Secretary will redirect the enforcement process to reasonably insure that facilities cannot predict the timing of survey/certification visits and to provide facilities with incentives to maintain high quality care delivery between surveys.

In evaluating the adequacy of the Secretary's plan, the court will use, inter alia, as a guide:

1. The Patient Classification for Long Term Care User's Manual (Exhibit 16),

2. The Long Term Health Care Minimum Data set (Exhibit 205),

3. The Department of Health and Human Service's Proposed Revision of the Conditions of Participation For Skilled Nursing and Intermediate Care Facilities published in the Federal Register on July 14, 1980 and the comments on said regulations submitted by plaintiffs and plaintiffs in intervention (Exhibits 222 and 224),

4. Patient Care Management: Theory to Practice (Exhibit 189),

5. Harvard and Michigan Assessment Instruments (Exhibits 92 and 138),

6. The August 6, 1980 Joint Motion for Stay Upon Stipulated Conditions (Exhibit 299), and

7. "Changing the Survey Process," by Janice Caldwell (Exhibit 226, No. 3 of 4).

IT IS FURTHER ORDERED, that after the submission of the plan by the Secretary, a hearing will be held at which time plaintiffs and plaintiffs in intervention shall be entitled to present their objections and any evidence relative to the lawfulness and/or inadequacies of the plan. After such submissions and hearing, the court will either reject, modify or approve the Secretary's plan. After approval of the plan by the court, the Secretary shall have six months to fully implement the approved plan. The Secretary shall submit to both the court and the parties to this proceeding an interim progress report concerning implementation of the court approved plan three months after entrance of the court order approving the plan.

FINALLY, IT IS ORDERED that the court shall retain jurisdiction over this action for the purpose of construing or enforcing this injunction, and granting any other or further relief that may be necessary.

DATED: ____________________

BY THE COURT:

____
RICHARD P. MATSCH, JUDGE
UNITED STATES DISTRICT COURT

CERTIFICATE OF MAILING

I certify that I mailed a copy of Appellants' Opening Brief and Appendix on August 15, 1983, to:

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10-29-84 83-1442 - 83-1466

United States Court of Appeals

For the Tenth Circuit

SLIP OPINION

PUBLISH

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

FILED
United States Court of Appeals
Tenth Circuit
OCT 29 1984
HOWARD K. PHILLIPS
Clerk

In re the Estate of)
MICHAEL PATRICK SMITH, et al.)
)
Plaintiffs-Appellants,)
)
and)
)
PEOPLE OF THE STATE OF)
COLORADO, et al.,) Nos. 83-1442
) 83-1466
Plaintiffs in Intervention-)
Appellants,)
)
v.)
)
MARGARET HECKLER, et al.)
)
Defendants-Appellees.)

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO
(D.C. Case No. 75-M-539)

Kathleen Mullens, Legal Aid Society of Metropolitan Denver (and John Robert Holland, Denver, Colorado, for Medicaid Nursing Home, Appellants, with Kristie A. Hansen, Attorney for State Appellants, on the brief).

Shalom Brilliant, Civil Division, Department of Justice, Washington, D.C. (with J. Paul McGrath, Assistant Attorney General; Robert N. Miller, United States Attorney, Denver, Colorado; and Lewis K. Wise, Civil Division, Department of Justice, Washington, D.C., on the brief) for Appellee.

Amicus Brief by Glenn W. Merrick, Denver, Colorado, for Concerned Friends and Relatives of Nursing Home Residents.

Amicus Brief by Michael C. Parks and Sylvia Drew Ivie, National Health Law Program, Los Angeles, California; and Toby S. Edelman and Patricia B. Nemore, National Senior Citizens Law Center, Washington, D.C., for the National Citizens Coalition for Nursing Home Reform and Gray Panthers of Denver.

Before SETH, and McKAY, Circuit Judges, and CAMPOS, District Judge.*

McKAY, Circuit Judge.

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*Honorable Santiago E. Campos, United States District Judge, District of New Mexico, sitting by designation.

Plaintiffs, seeking relief under 42 U.S.C. § 1983 (1982), brought this class action on behalf of medicaid recipients residing in nursing homes in Colorado. They alleged that the Secretary of Health and Human Services (Secretary) has a statutory duty under Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396n (1982), commonly known as the Medicaid Act, to develop and implement a system of nursing home review and enforcement designed to ensure that medicaid recipients residing in medicaid certified nursing homes actually receive the optimal medical and psychosocial care that they are entitled to under the Act. The plaintiffs contended that the enforcement system developed by the Secretary is "facility-oriented," not "patient oriented" and thereby fails to meet the statutory mandate. The district court found that although a patient care or "patient oriented" management system is feasible, the Secretary does not have a duty to introduce and require the use of such a system. _In re Estate of Smith v. O'Halloran_, 557 F. Supp. 289, 295 (D. Colo. 1983).

The primary issue on appeal is whether the trial court erred in finding that the Secretary does not have a statutory duty to develop and implement a system of nursing home review and enforcement which focuses on and ensures high quality patient care. If the Secretary has such a duty we must determine whether the enforcement mechanism promulgated by the Secretary satisfies that duty.

BACKGROUND

The factual background of this complex lawsuit is fully discussed in the district court's opinion. In re Estate of Smith v. O'Halloran, 557 F. Supp. 289 (D. Colo. 1983). Briefly, plaintiffs instituted the lawsuit in an effort to improve the deplorable conditions at many nursing homes. They presented evidence of the lack of adequate medical care and of the widespread knowledge that care is inadequate. Indeed, the district court concluded that care and life in some nursing homes is so bad that the homes "could be characterized as orphanages for the aged." Id. at 293.

When the suit was filed in 1975, plaintiffs named Colorado nursing home operators, and federal and Colorado state governmental agencies and officials as defendants. In 1978, plaintiffs and the Colorado governmental defendants stipulated to dismissal, without prejudice, of the claims against the Colorado governmental defendants. Pursuant to the stipulation, the state defendants filed a complaint in intervention on behalf of the people of Colorado against the federal defendants. After extensive pretrial discovery and preparation, the district court ordered separate trials for the federal defendant and the nursing home operators.

In 1980, the plaintiffs, plaintiffs in intervention and federal defendant jointly moved for a stay, based on proposed regulatory revisions, which the plaintiffs and plaintiffs in intervention believed would accomplish the ultimate objective of the litigation. However, the proposed changes in the regulations were never adopted and the lawsuit against the federal defendant proceeded to trial in June 1982. The trial court denied relief. This appeal is from that judgment.

THE MEDICAID ACT

An understanding of the Medicaid Act (the Act) is essential to understand plaintiffs' contentions. The purpose of the Act is to enable the federal government to assist states in providing medical assistance to "aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and ... rehabilitation and other services to help such ... individuals to attain or retain capabilities for independence or self care." 42 U.S.C. § 1396 (1982). To receive funding, a state must submit to the Secretary and have approved by the Secretary, a plan for medical assistance which meets the requirements of 42 U.S.C. § 1396a(a).

The district court detailed the requirements of section 1396a(a). *See* 557 F. Supp. at 294-95. A state seeking plan approval must establish or designate a single state agency to administer or supervise administration of the state plan, 42 U.S.C. § 1396a(a)(5), and must provide reports and information as the Secretary may require. Id. § 1396a(a)(6). Further, the state agency is responsible for establishing and maintaining health standards for institutions where the recipients of the medical assistance under the plan receive care or services. Id. § 1396a(a)(9)(A). The plan must include descriptions of the standards and methods the state will use to assure that medical or remedial care services provided to the recipients "are of high quality." Id. § 1396a(a)(22)(D).

The state plan must also provide "for a regular program of medical review ... of each patient's need for skilled nursing facility care ..., a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility...."[1] Id. § 1396a(a)(26)(A). Further, the plan must provide for periodic inspections by medical review teams of:

> (i) the care being provided in such nursing facilities ... to persons receiving assistance under the State plan; (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities ... to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities ...; (iii) the necessity and desirability of continued placement of such patients in such nursing facilities ...; and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services.

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[1] The Act defines various health care services that qualify for federal assistance. Relevant here are skilled nursing facilities, § 1396d(a)(4) and § 1396d(f), which states must have to receive funding, and intermediate care facilities, § 1396d(a)(15) and § 1396d(c) and (d), which states may receive funding to operate, but states are not required to operate.

Id. § 1396a(a)(26)(B).[2]

The state plan must provide that any skilled nursing facility receiving payment comply with 42 U.S.C. § 1395x(j), which defines "skilled nursing facility" and sets out standards for approval under a state plan. Id. § 1396a(a)(28). The key requirement for purposes of this lawsuit is that a skilled nursing facility must meet "such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary...." Id. § 1395x(j)(15).

The state plan must provide for the appropriate state agency to establish a plan, consistent with regulations prescribed by the Secretary, for professional health personnel to review the appropriateness and quality of care and services furnished to Medicaid recipients. Id. § 1396a(a)(33)(A). The appropriate state agency must determine on an ongoing basis whether participating institutions meet the requirements for continued participation in the Medicaid program. Id. § 1396a(a)(33)(B). While the state has the initial responsibility for determining whether institutions are meeting the conditions of participation, section 1396a(a)(33)(B) gives the Secretary the authority to "look behind" the state's determination of facility compliance, and make an independent and binding determination of whether institutions meet the requirements for participation in the state Medicaid plan. Thus, the state is responsible for conducting the review of facilities to determine whether they comply with the state plan. In conducting the review, however, the states must use federal standards, forms, methods and procedures. 42 C.F.R. § 431.610(f)(1) (1983). From 1972 through 1980, Congress required the Secretary to reimburse the states for all necessary costs of inspecting long-term care facilities. See 42 U.S.C. § 1396b(a)(4) (1982) (codification). In 1980, Congress reduced the rate of reimbursement to seventy-five percent of such costs. Id. § 1396b(a)(2).

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[2] The state plan must provide for similar review of intermediate care facilities. § 1396a(a)(31).

The Secretary "shall aprove" any plan which fulfills the requirements of section 1396a(a). Id. § 1396a(b). Once the state plan is approved, the Secretary reimburses the states according to percentages set out in section 1396b. If the state fails to show that it has an effective program of "utilization control" as defined in section 1396b(g)(3), the Secretary must reduce the percentage of reimbursement to the state. If after approving a state plan, the Secretary determines that the plan has been so changed that it no longer complies with section 1396a(a), or that it complies on paper but not in its actual administration, the Secretary is required to terminate payments to the state, effectively disapproving the plan. Id. § 1396c.

IMPLEMENTING REGULATIONS

Congress gave the Secretary a general mandate to promulgate rules and regulations necessary to the efficient administration of the functions with which the Secretary is charged by the Act. 42 U.S.C. § 1302 (1982). Pursuant to this mandate the Secretary has promulgated standards for the care to be provided by skilled nursing facilities and intermediate care facilities. See 42 C.F.R. § 442.200-.516 (1983). Among other things, the regulations provide for the frequency and general content of patients' attending physician evaluations, 42 C.F.R. § 405.1123(b), nursing services with policies "designed to ensure that each patient receives treatments, medications, ... diet as prescribed, ... rehabilitative nursing care as needed ..., is kept comfortable, clean, well-groomed, [is] protected from accident, injury, an infection, and [is] encouraged, assisted, and trained in self-care and group activities." 42 C.F.R. § 405.1124(c). The rehabilitative nursing care is to be directed toward each patient achieving an optimal level of self-care and independence. Id. § 405.1124(e). The regulations require a written patient care plan to be developed and maintained for each patient. Id. § 405.1124(d). In addition to the rehabilitative nursing care provided for in section 405.1124(c) and (e), section 405.1126 provides specific standards for specialized rehabilitative services, as needed by patients to improve and maintain functioning. Finally, the regulations provide for treatment of the social and emotional needs of recipients. Id. § 405.1130.

The Secretary has established a procedure for determining whether state plans comply with the standards set out in the regulations. This enforcement mechanism is known as the "survey/certification" inspection system. Under this system, the states conduct reviews of nursing homes pursuant to 42 U.S.C. § 1396a(a)(33). The Secretary then determines, on the basis of the survey results, whether the nursing home surveyed is eligible for certification and, thus, eligible for Medicaid funds. The states must use federal standards, forms, methods and procedures in conducting the survey. 42 C.F.R. § 431.610(f)(1). At issue in this case is the form SSA-1569, record, appendix vol. 1, at 93-127, which the Secretary requires the states to use to show that the nursing homes participating in Medicaid under an approved state plan meet the conditions of participation contained in the Act and the regulations. Plaintiffs contend that the form is "facility-oriented," in that it focuses on the theoretical capability of the facility to provide high quality care, rather than "patient-oriented," which would focus on the care actually provided. The district court found, with abundant support in the record, that the "facility-oriented" characterization is appropriate and that the Secretary has repeatedly admitted that the form is "facility-oriented." In re Estate of Smith, 557 F. Supp. at 295.

THE PLAINTIFFS' CLAIMS

Plaintiffs contend that the statutory requirements regarding the content of state plans create a correlative entitlement for

Medicaid recipients to quality care. They argue that the Secretary has an enforcement obligation to insure compliance with the approved state plan. More specifically, plaintiffs argue that the Secretary has a statutory duty to develop an enforcement system whereby to receive medicaid funds states would be forced to use a patient care management system. Such a system would ensure, through the review process of section 1396a(a)(33), that Medicaid recipients residing in nursing homes certified for Medicaid participation are "actually, continuously receiving their Medicaid entitlements to optimal medical and psychosocial care in a safe, sanitary, rehabilitatively supportive, accessible, personalized environments and in a context of full civil liberties as a condition of such facilities' receipt of Federal and State financial reimbursement from the Medicaid Program." _In re Estate of Smith_, 557 F. Supp. at 292.

The plaintiffs do not challenge the substantive medical standards, or "conditions of participation," which have been adopted by the Secretary and which states must satisfy to have their plans approved. _See_ 42 C.F.R. § 405.1101-.1137. Rather, plaintiffs challenge the enforcement mechanism the Secretary has established. The plaintiffs contend that the federal forms, form SSA-1569 in particular, which states are required to use, evaluate only the physical facilities and theoretical capability to render quality care. The surveys assess the care provided almost totally on the basis of the records, documentation and written policies of the facility being reviewed. Appellants' brief at 10 (citing 45 Fed. Reg. 47,368 (1980)). Further, out of the 541 questions contained in the Secretary's form SSA-1569 which must be answered by state survey and certification inspection teams, only 30 are "even marginally related to patient care or might require any patient observation...." Appellants' brief at 10. Plaintiffs contend that the enforcement mechanism's focus on the facility, rather than on the care actually provided in the facility, results only in "paper compliance" with the substantive standards of the Act. Thus, plaintiffs contend, the Secretary has violated her statutory duty to assure that federal Medicaid monies are paid only to facilities which meet the substantive standards of the Act -- facilities which actually provide high quality medical, rehabilitative and psychosocial care to resident Medicaid recipients.

THE DISTRICT COURT'S HOLDING

After hearing the evidence, the district court found the type of patient care management system advocated by plaintiffs clearly feasible and characterized the current enforcement system as "facility-oriented." In re Estate of Smith, 557 F. Supp. at 295. However, the court concluded that the failure to implement and require the use of a "patient-oriented" system is not a violation of the Secretary's statutory duty. Id. The essence of the district court's holding was that the State of Colorado, not the federal government, is responsible for developing and enforcing standards which would assure high quality care in nursing homes and, thus, the State of Colorado, not the federal government, should have been the defendant in this case. Id. at 297.

The district court found that the duty lies with the state because the Medicaid Act provides that states are responsible for establishing and maintaining health standards for provider institutions, 42 U.S.C. § 1396a(a)(9)(A), and the states determine what kind and how many professional medical and supporting personnel will be used to administer the state plan. Id. § 1396a(a)(22)(A). The state plan must include standards and methods which the state will use to assure that the medical assistance provided is of high quality. Id. § 1396a(a)(22)(D). Section 1396a(a)(33) provides that the responsibility for inspecting nursing homes for survey and certification purposes lies with the state. In re Estate of Smith, 557 F. Supp. at 295-96.

The district court also concluded that the "look behind" provision of section 1396a(a)(33)(B), authorizing the Secretary to reject a survey/certification performed by the state agency and substitute her own independent and binding determination, is "nothing more than permitted authority to intervene for the purpose of protecting the public funds used to reimburse the state." Id. at 296. Nor did the district court believe that section 1302, the general mandate to make rules and regulations, imposes by itself, a rulemaking duty on the Secretary. Further, the trial court held that, even if the Secretary has a duty to promulgate such regulations when section 1302 is read with section

1396a(a)(33)(A), the Secretary has satisfied that duty by promulgating the detailed regulations founds in 42 C.F.R. Parts 430-456. 557 F. Supp. at 296.

The district court also found it significant that under Colorado law, the State of Colorado is responsible for licensing nursing homes, suspending a license if the public health or welfare is endangered, for regulating nursing home administration, and licensing and regulating the various professions which provide care in nursing homes. Id. at 297-98. The district court found that these state statutes provided further credibility to its interpretation of the statute, that the state is primarily responsible for administering and enforcing the Medicaid Act and the role of the federal government is essentially limited to providing financial assistance to states which meet the statutory requirements for participation. Id. at 296.

THE SECRETARY'S DUTY

After carefully reviewing the statutory scheme of the Medicaid Act, the legislative history, and the district court's opinion, we conclude that the district court improperly defined the Secretary's duty under the statute. The federal government has more than a passive role in handing out money to the states. The district court erred in finding that the burden of enforcing the substantive provisions of the Medicaid Act is on the states. The Secretary of Health and Human Services has a duty to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act, including providing high quality patient care. This duty to be adequately informed is not only a duty to be informed at the time a facility is originally certified, but is a duty of continued supervision.

Nothing in the Medicaid Act indicates that Congress intended the physical facilities to be the end product. Rather, the purpose of the Act is to provide medical assistance and rehabilitative services. 42 U.S.C. § 1396. The Act repeatedly focuses on the care to be provided, with facilities being only part of that care. For example, the Act provides that health standards are to be developed and maintained, id. § 1396a(a)(9)(A), and that states must inform the Secretary what methods they will use to assure high quality care. Id. § 1396a(a)(22). In addition to the "adequacy of the services available," the periodic inspections must address "the care being provided" in nursing fracilities. Id. § 1396a(a)(26)(B). State plans must provide review of the "appropriateness and quality of care and services furnished," id. § 1396a(a)(33)(A), and do so on an ongoing basis. Id. § 1396a(a)(33)(B).

While the district court correctly noted that it is the state which develops specific standards and actually conducts the inspection, there is nothing in the Act to indicate that the state function relieves the Secretary of all responsibility to ensure that the purposes of the Act are being accomplished. The

Secretary, not the states, determines which facilities are eligible for federal funds. See Conf. Rep. No. 1605, 92nd Cong., 2d Sess., reprinted in 1972 U.S. Code Cong. & Ad. News, 5370, 5390. While participation in the program is voluntary, states who choose to participate must comply with federal statutory requirements. Harris v. McRae, 448 U.S. 297, 301 (1980); Mississippi Hospital Association, Inc. v. Heckler, 701 F.2d 511, 515 (5th Cir. 1983). The inspections may be conducted by the states, but the Secretary approves or disapproves the state's plan for review. Further, the inspections must be made with federal forms, procedures and methods.

It would be anomalous to hold that the Secretary has a duty to determine whether a state plan meets the standards of the Act while holding that the Secretary can certify facilities without informing herself as to whether the facilities actually perform the functions required by the state plan. The Secretary has a duty to ensure more than paper compliance. The federal responsibility is particularly evident in the "look behind" provision. 42 U.S.C. § 1396a(a)(33)(B) (1982). We do not read the Secretary's "look behind" authority as being "nothing more than permitted authority ...," 557 F. Supp. 296, as the district court found. Rather, we find that the purpose of that section is to assure that compliance is not merely facial, but substantive.

The legislative history makes clear that the "look behind" provision was added to the Act because the states were not properly carrying out the function of making sure that facilities were providing high quality care. The House report states:

> [T]he Committee is concerned that, without the authority to validate State agency compliance reviews and to make an independent judgment as to the extent of compliance by particular facilities, the Secretry lacks the means necessary to assure that Federal matching funds are being used to reimburse only those [skilled nursing facilities] and [intermediate care facilities] that actually comply with medicaid requirements.

H.R. Rep. No. 1167, 96th Cong., 2d Sess., _reprinted in_ 1980 U.S. Code Cong. & Ad. News 5526, 5570. The district court's conclusion that this section merely provides the Secretary the authority to go behind a state's determination of compliance if and when the Secretary wants to, but imposes no duty on the Secretary, ignores the purpose of the section and eliminates its effectiveness.

By enacting section 1302 Congress gave the Secretary authority to promulgate regulations to achieve the functions with which she is charged. The "look-behind" provision and its legislative history clearly show that Congress intended the Secretary to be responsible for assuring that federal Medicaid money is given only to those institutions that actually comply with Medicaid requirements. The Act's requirements include providing high quality medical care and rehabilitative services. In fact, the quality of the care provided to the aged is the focus of the Act. Being charged with this function, we must conclude that a failure to promulgate regulations that allow the Secretary to remain informed, on a continuing basis, as to whether facilities receiving federal money are meeting the requirements of the Act, is an abdication of the Secretary's duty. While the Medicaid Act is admittedly very complex and the Secretary has "exceptionally broad authority to prescribe standards for applying certain sections of the Act," Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981), the Secretary's authority cannot be interpreted so as to hold that that authority is merely permissive authority. The Secretary must insure that states comply with the Congressional mandate to provide high quality medical care and rehabilitative services.

The district court made a factual finding that the Secretary's current method of informing herself as to whether the facilities in question are satisfying the statutory requirements is "facility-oriented," rather than "patient-oriented." 557 F. Supp. at 295. This characterization is fully supported by the record. Having determined that the purpose and the focus of the Act is to provide high quality medical care, we conclude that by promulgating a facility-oriented enforcement system the Secretary has failed to follow that focus and such failure is arbitrary and capricious. See Heckler v. Campbell, ___ U.S. ___, 103 S. Ct. 1952, 1957 (1983).[3]

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[3] Our conclusions are further evidenced by Congress' recent amendment to the Medicaid Act. Tax Reform Act of 1984, Pub. L. No. 98-369 (1984). Directly in response to the district court's opinion in this case, Congress amended the Act specifically imposing upon the Secretary a duty to assure that Medicaid patients in skilled nursing and intermediate care facilities receive high quality medical care. The legislative history indicates that Congress was merely reaffirming the Secretary's duty under existing law because Congress believed the district court misinterpreted the statute. 130 Cong. Rec. H 6544, 6740

(continued on next page)

REMEDY

The district court found that the Secretary owed no duty to the plaintiffs and thus denied the requested relief. Plaintiffs contend that the district court has jurisdiction to compel the Secretary to perform her statutory duty pursuant to the Mandamus and Venue Act of 1962, 28 U.S.C. § 1361 (1982), federal question jurisdiction, 28 U.S.C. § 1331 (1982), and the Administrative Procedure Act, 5 U.S.C. §§ 701-706 (1982).

This court considered the mandamus remdy in Carpet, Linoleum and Resilient Tile Layers, Local Union No. 419 v. Brown, 656 F.2d 564 (10th Cir. 1981). We repeated there the general rule that mandamus is appropriate where the person seeking the relief "can show a duty owed to him by the government official to whom the writ is directed that is ministerial, clearly defined and peremptory." Id. at 566 (quoting Schulke v. United States, 544 F.2d 453, 455 (10th Cir. 1976)). This ministerial-discretionary dichotomy, we noted, "is merely shorthand for the well-taken rule that to the extent a statute vests discretion in a public official, his exercise of that discretion should not be controlled by

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(continued from previous page)
(daily ed. June 22, 1984); Deficit Reduction Act of 1984, Conf. Rep. No. 861, 98th Cong., 2d Sess. 1363 (1984). We do not address the issue of whether a current legislature's comment on the intent of a previous legislature is binding. However, the amendment and its legislative history make the Secretary's duty under the Act even more clear.

the judiciary." *Id.* The judiciary is not a "super agency" controlling the affairs of an agency which is part of another branch of government. *Id.*

> [I]t is the court's duty in a mandamus action to measure the allegations in the complaint against the statutory and constitutional framework to determine whether the particular official actions complained of fall within the scope of the discretion which Congress accorded the administrators.... In other words, even in an area generally left to agency discretion, there may well exist statutory or regulatory standards delimiting the scope or manner in which such discretion can be exercised. In these situations, mandamus will lie when the standards have been ignored or violated.

Id. (quoting *Davis Associates, Inc. v. Secretary, Department of Housing and Urban Development*, 498 F.2d 385, 389 & n.5 (1st Cir. 1974)). If, after studying the statute and its legislative history, the court determines that the defendant official has failed to discharge a duty which Congress intended him to perform, the court should compel performance, thus effectuating the congressional purpose. *Carpet, Linoleum and Resilient Tile Layers*, 656 F.2d at 566.

We also held in *Carpet, Linoleum and Resilient Tile Layers* that 28 U.S.C. § 1331 gives the district court jurisdiction to issue a mandatory injunction. The injunctive remedy is provided for by the Administrative Procedure Act, 5 U.S.C. § 706(1), where a court reviewing agency action is authorized to "compel agency action unlawfully withheld." Thus, in *Carpet, Linoleum and*

Resilient Tile Layers, 656 F.2d at 567, we concluded that a mandatory injunction is essentially in the nature of mandamus, and jurisdiction can be based on either 28 U.S.C. § 1361, § 1331, or both.

Applying these principles, we find that jurisdiction exists and mandamus is an appropriate remedy. The Secretary has a duty to promulgate regulations which will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care. This conclusion is fully supported by the statute and its legislative history. The statute vests broad discretion in the Secretary as to how that duty is best accomplished. The court is not a "super agency" and cannot control the specifics of how the Secretary satisfies the duty. This is not a question of controlling the Secretary's discretion because the Secretary has failed to discharge her statutory duty altogether. Thus, the court should "compel performance and thus effectuate the congressional purpose," behind the statutory scheme. Carpet, Linoleum and Resilient Tile Layers, 656 F.2d at 566. The case is thus remanded for further proceedings not inconsistent with this opinion.

REVERSED AND REMANDED.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 75-M-539

In re the Estate of:

MICHAEL PATRICK SMITH, et al.,

Plaintiffs,

and

PEOPLE OF THE STATE OF COLORADO, et al.,

Plaintiffs in intervention,

v.

MARGARET M. HECKLER,
Secretary of Health and Human Services,

Defendant.

FILED
UNITED STATES DISTRICT COURT
DENVER, COLORADO
AUG 9 1985
JAMES R. MANSPEAKER
CLERK

MEMORANDUM OPINION AND ORDER

On April 29, 1985, this court ordered the Secretary of Health and Human Services (the "Secretary") to file a plan of action with the court setting forth the procedures and timetable to be followed in performing the duty required by 42 U.S.C. SS 1396-1396n as mandated by the Tenth Circuit Court of Appeals in Estate of Smith v. Heckler, 747 F.2d 583 (10th Cir. 1984). On June 10, 1985, the Secretary filed that plan. On June 19, 1985, the plaintiffs and plaintiffs in intervention filed a reponse to the Secretary's plan and a motion for review proceedings. In addition, on May 14, 1985, the plaintiffs filed an application for attorney's fees, seeking $352,689 in fees.

ATTORNEYS' FEES

The plaintiffs assert that they are entitled to attorney's fees under (1) 42 U.S.C. S 1988, (2) 28 U.S.C. S 2412(b), and (3) 28 U.S.C. S 2412(d).

42 U.S.C. S 1988

42 U.S.C. S 1988 provides:

> In any action or proceeding to enforce a provision of sections 1981,

> 1982, 1983, 1985, and 1986 of this title, title IX of Public Law 92-318, or title VI of the Civil Rights Act of 1964, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.

This suit was brought as a civil rights action seeking remedies under 42 U.S.C. S 1983 for alleged violations of constitutional rights. The defendants were the Secretary (then the Secretary of the Department of Health, Education and Welfare), the officers of the Colorado Department of Social Services and the Colorado Department of Health, and the owners and administrators of a nursing home. Initially it must be pointed out that by the time of trial, the claims against the state defendants had been dismissed by stipulation and the state defendants had become plaintiffs in intervention. In Re Estate of Smith, 557 F. Supp. 289, 290-291 (D. Colo. 1983). In addition, this court ordered separate trials against the federal defendant and the nursing home defendants. The case against the federal defendant went to trial in May, 1982, and resulted in the judgment of dismissal of all claims against the Secretary reported at In Re Estate of Smith, supra. On appeal, the Tenth Circuit Court of Appeals reversed and remanded the case to this court for further proceedings, finding that the Secretary had violated her statutory duty "to promulgate regulations which will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care." Estate of Smith v. Heckler, 747 F.2d at 591. It is for work done against the federal defendant that the plaintiffs now seek an award of attorneys' fees.

Under 42 U.S.C. S 1983:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

To state a claim for relief under S 1983, the plaintiff must show that the defendant was acting under color of state law and deprived the plaintiff of a right secured by the Constitution or laws of the United States. Ibgpl v. Usery, 601 F.2d 1091 (9th Cir. 1979). Section 1983 "does not apply to federal officers acting under color of federal law." Campbell v. Amax Coal Co., 610 F.2d 701, 702 (10th Cir. 1979).

The Secretary was not acting under color of state law. The Tenth Circuit Court of Appeals stated in this case:

> The federal government has more than a passive role in handing out money to the states. The district court erred in finding that the burden of enforcing the substantive provisions of the Medicaid Act is on the states. The Secretary of Health and Human Services has a duty to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act.

Estate of Smith v. Heckler, 747 F.2d at 589. As the only defendant in this case at the time of trial was the federal defendant, acting under color of federal law, the plaintiffs have not stated, nor could they state, a claim for relief under S 1983.

The plaintiffs argue that Tongol v. Usery, 575 F. Supp. 409 (N.D. Cal. 1983) allows a fee award under S 1988 "against a federal defendant where the plaintiffs' S 1983 claim initially lay against both state and federal officials, as here." (Plaintiffs' Brief p. 4). The district court did award attorneys' fees against the federal defendant in that case stating that "where federal defendants are found to have acted in concert or conspiracy with state officials, courts have held that they could be liable as state actors under S 1983." Id. at 415. However, the award of attorneys' fees against the federal defendant in Tongol was later reversed on the ground that the case was no longer pending against the federal defendant at the time the EAJA went into effect because the only unresolved issue was the nonfederal co-defendant's liability for attorneys' fees. Tongol v. Donovan, 762 F.2d 727 (9th Cir. 1985).

As no claim may be stated against the Secretary under S 1983, the Secretary has not violated any of the provisions enumerated in S 1988, and the plaintiffs are not entitled to an award of attorneys' fees under S 1988.

28 U.S.C. S 2412(b)

The plaintiffs next assert that they are entitled to an award of attorneys' fees under the Equal Access to Justice Act ("EAJA"), 28 U.S.C. S 2412. Section (b) of that statute provides:

> Unless expressly prohibited by statute, a court may award reasonable fees and expenses of attorneys, in addition to the costs which may be

> awarded pursuant to subsection (a), to the prevailing party in any civil action brought by or against the United States or any agency and any official of the United States acting in his or her official capacity in any court having jurisdiction of such action. The United States shall be liable for such fees and expenses to the same extent that any other party would be liable under the common law or under the terms of any statute which specifically provides for such an award.

The plaintiffs rely principally on the decision in Trujillo v. Heckler, 587 F. Supp. 928 (D. Colo. 1984), in which the Secretary was enjoined from terminating social security disability benefits under certain conditions. Judge Kane awarded attorneys' fees to the plaintiffs under 28 U.S.C. S 2412(b) on the basis that S 1988, as incorporated into the EAJA, allows for an award of attorneys' fees against the United States in suits for violations of constitutional or statutory violations under color of federal law. Judge Kane was guided in his decision by two cases, Lauritzen v. Secretary of the Navy, 546 F. Supp. 1221 (C. D. Calif. 1982) and Premachandra v. Mitts, 727 F.2d 717 (8th Cir. 1984), holding that a deprivation of constitutional rights by a federal officer acting under color of federal law is "analogous" to a S 1983 claim, entitling a plaintiff to an award of attorneys' fees under S 1988, by virtue of the waiver of sovereign immunity provided in S 2412. Both of those decisions have since been reversed. Lauritzen v. Lehman, 736 F.2d 550 (9th Cir. 1984); Premachandra v. Mitts, 753 F.2d 635 (8th Cir. 1985)(en banc). The plaintiffs also cite Boudin v. Thomas, 732 F.2d 1107 (2nd Cir. 1984) in support of their position. There the Second Circuit Court of Appeals stated that attorneys' fees could be awarded against the United States if the "fundamentally analogous" state habeas action would authorize an award of fees, also relying on the earlier decisions in Lauritzen and Premachandra.

The position advanced by the plaintiffs is against the clear weight of authority. The circuits which have directly addressed the issue of whether the federal government may be taxed with attorneys' fees for violations of federal statutes or deprivations of constitutional rights under color of federal law have held that 28 U.S.C. S 2412(b) does not authorize attorneys' fees against the federal government in actions "analogous" to S 1983 actions. Unification Church v. Immigration & Naturalization Service, No. 81-10173 (D. C. Cir. June 4, 1985); Lauritzen, 736 F.2d 550; Premachandra, 753 F.2d 635.

In Premachandra, the plaintiff's lawsuit was brought against federal officials for alleged violations of his fifth amendment rights. The plaintiffs point to the following language in Premachandra as distinguishing that case:

> Section 1983 is the only statute named in section 1988 that provides a remedy for violations of the Constitution. Because Premachandra did not allege that the defendants acted under color of state law, no section 1983 liability could be found. ... Thus, the action was not brought to "enforce a provision" enumerated in section 1988. Consequently, there is no statute that specifically provides for attorneys' fees in this case, and section 2412(b) does not apply.

Premachandra, 753 F.2d at 637. Because the Secretary was not acting under color of state law for purposes of S 1983, this action was not brought to enforce a provision enumerated in S 1988. As no statute specifically provides for an award of attorneys' fees, S 2412(b) does not apply.

The plaintiffs also point to language in Lauritzen which reads: "[W]e hold that where the government has violated a particular substantive statute, and attorney's fees may be awarded against any other party for violation of that statute, the government is also liable for fees." Lauritzen, 736 F.2d at 559. The plaintiffs argue that since the state could be held liable for fees for violating the plaintiffs' rights under the Social Security Act, the federal government may as well. The plaintiffs do not say how the state could be held liable for attorneys' fees for violating the Act, unless by virtue of S 1988 through a S 1983 suit. While this quotation is somewhat confusing, it must be read in the context of the entire case in which the Ninth Circuit Court of Appeals held that a fee award was not allowable against the federal defendant acting under color of federal law where the claim was "analogous" to a S 1983 claim.

Finally, the plaintiffs point to language in Unification Church, supra, that no violation of state law was at issue, as distinguishing that case. No violation of state law was at issue with respect to the federal defendant in this case either.

As clearly explained by the District of Columbia Circuit Court of Appeals:

> Applying the government's interpretation of subsection (b) would mean that the United States would be liable for fees when it was a losing defendant in proceedings to enforce the statutes listed in section 1988. Applying this interpretation to this case, the United States is not liable

> for fees. It did not violate section 1983, because it did not violate the appellants' rights under color of state law, as required by the words of section 1983. It did violate the appellants' rights under color of federal law, but that creates no cause of action under section 1983. Since it did not violate section 1983, it is not liable for fee awards under Section 1988, and thus not liable for fees awarded under subsection (b) of the [EAJA].

Unification Church, supra, at 6.

The plaintiffs are not entitled to an award of attorneys' fees against the Secretary under 28 U.S.C. § 2412(b).

28 U.S.C. § 2412(d)

The plaintiffs' final argument is that they are entitled to an award of attorneys' fees under 28 U.S.C. § 2412(d)(1)(A) which provided, prior to its repeal effective October 1, 1984:

> Except as otherwise specifically provided by statute, a court shall award to a prevailing party other than the United States fees and other expenses, in addition to any costs awarded pursuant to subsection (a), incurred by that party in any civil action (other than cases sounding in tort) brought by or against the United States in any court having jurisdiction of that action, unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust.

In the Tenth Circuit, "the test of substantial justification is essentially one of reasonableness in both law and fact." United States v. 2,116 Boxes of Boned Beef, 726 F.2d 1481, 1486 (10th Cir. 1984), cert. denied, ___ U.S. ___, 105 S. Ct. 105 (1984). "[T]he position of the United States, for purposes of this Act, means the arguments relied upon by the government in litigation." Id. at 1487.

The plaintiffs argue that "[w]hile there may be room for substantial debate as to whether or not the federal defendant's legal position in the litigation was substantially justified, we submit that the factual position of the federal defendant lacked substantial justification." (Plaintiffs' brief, p. 7). The plaintiffs assert that

> [t]he record adduced at trial was replete with the federal defendant's own documents showing repeated acknowledgements and admissions of the failures of the existing inspection system, and the need for a substitute system such as that plaintiffs sought. Nevertheless, the federal defendant not only contested the legal power of the court to effectuate a remedy, but equally important, contested the factual predicate of plaintiffs' case. Had

> the federal government simply taken the position that the court was not empowered to act, by admitting the factual circumstances, the trial could have been shortened or obviated, and the matter could have been determined on a motion for summary judgment, saving the court hundreds of hours of time, and the litigants and their attorneys substantial time, expense and delay.

(Plaintiffs' brief, pp. 7-8). The plaintiffs' attempt to place the blame on the defendants for the length and complexity of the trial is misplaced. In August, 1981, the federal defendant moved for judgment on the pleadings. In their opposition, the plaintiffs argued:

> 1. The court has been asked by Federal Defendant on repeated occassion [sic] both by formal motion and by oral request at hearings to decide the matters at issue on a summary judgment or motion to dismiss and now on a Motion for Judgment on the pleadings basis.
>
> 2. At each request counsel for the parties plaintiffs have pointed out often after written response, the court's previous denials of such motions on multiple occassions [sic] and the fact that the Court had indicated its clear intention not to decide the case without first providing the parties with a full opportunity to present the evidence that has been gathered in over 6 years of case preparation and for the reasons set forth in 5 and 6 below.
>
> ***
>
> 5. As plaintiffs have pointed out all along the duty of the federal defendant in this case significantly involves, inter alia, an evidentiary analysis of the historical administrative construction of that duty by succeeding secretaries and a review of the agency's actions in interpreting and implementing its responsibilities thereunder. Substantial documentary and testimonial evidence bear directly on the duty and on the failures of the Department and the Secretary to discharge it. In the absence of its full presentation the Court can not fully evaluate the plaintiffs [sic] claims.
>
> 6. Likewise establishment of the breach of the Secretary's duties involves substantial documentary and testimonial evidence and can only be intelligently determined upon trial.

(Plaintiffs' Opposition to Motion for Judgment on the Pleadings, filed September 4, 1981). Thus it is clear that the plaintiffs felt that a full presentation of the factual evidence was necessary.

It is true that this court's decision was reversed by the Tenth Circuit Court of Appeals. However, in view of the fact that this court saw fit to rule in favor of the Secretary on every claim asserted against her, it cannot be said that the Secretary's position, both legal and factual, was not reasonable.

The plaintiffs are not entitled to an award of attorneys' fees against the Secretary under 28 U.S.C. S 2412(d), or under either of their other theories. The plaintiffs' application for attorneys' fees is denied.

As this court has determined that the plaintiffs are not entitled to an award of attorneys' fees against the Secretary, it is not necessary to address the parties' arguments concerning the reasonableness of the fees sought.

THE SECRETARY'S PLAN OF ACTION PURSUANT TO ORDER ON REMAND

On June 10, 1985, pursuant to order of this court, the Secretary filed her Plan of Action Pursuant to Order on Remand ("Plan"). The plaintiffs and plaintiffs in intervention have filed a response to that Plan and a Motion for Review Proceedings.

The Tenth Circuit ordered this court to "compel" the Secretary's performance of her statutory duty, while admonishing this court that it is not a "super agency" and "cannot control the specifics of how the Secretary satisfies the duty." Estate of Smith v. Heckler, 747 F.2d at 591. In its Order on Remand of April 29, 1985 ("Order"), this court ordered the Secretary to "file with this court a plan for action to be taken to perform the prescribed duty, specifically setting forth the procedures and timetable for proposing the required regulations and forms." The Secretary's Plan was in response to that Order.

In the Plan, the Secretary states that she is "currently in the process of studying changes to the survey method used by State survey agencies and federal surveyors," and that "[i]n order to comply with the duty defined by the Court of Appeals, she intends both to implement new survey procedures and forms and to propose appropriate revisions to the regulations to implement these changes." Her Plan involves two phases. She first plans to implement a new survey process. This would involve testing the new "outcome-oriented" survey process on an experimental basis, evaluating the test results and making necessary changes, developing a program to train surveyors, obtaining the final approval of the Department of Health and Human Services (HHS), training surveyors, obtaining the approval of the Office of Management and Budget (OMB), revising existing computer programs, revising the State Operations Manual, revising the Regional Office Manual, and, finally, implementing the new procedures in January, 1986 - all prior to any formal rule making proceedings.

The second phase of the Secretary's Plan involves developing a Notice of Proposed Rulemaking, obtaining clearance from OMB, publishing the Notice of Proposed Rulemaking, providing a sixty-day comment period, evaluating the comments, preparing the final regulation, obtaining clearance of the final regulation from OMB, and publishing the final regulation, with a target date for final publication of August 15, 1986.

The plaintiffs and plaintiffs in intervention have filed a Motion for Review Proceedings in which they ask that this court:

> A. Order Secretary Heckler to submit to the court and to plaintiffs and to plaintiffs-in-intervention within 10 days the alleged new "outcome-oriented survey process" which she intends to implement in January 1986 without any review by this court or any public rule making process;
>
> B. Set an evidentiary hearing in November 1985 to review whether the Secretary's proposed survey process has even the threshold potential for complying with her statutory duty and the mandate of the Tenth Circuit Court of Appeals that "she promulgate regulations which will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality care," Estate of Smith v. Heckler, 747 F.2d 583, 591 (10th Cir. 1984);
>
> C. Establish a discovery schedule which will allow all parties access to relevant information regarding the assumptions of the Secretary's proposed survey system, any results of field tests or other research related to the proposed survey system, any plans the Secretary has for further field testing, research, or refinement of the survey process, and any critiques of the proposed system which are received by the Department of Health and Human Services (HHS) or which will be presented to the court by any party during the review proceeding requested herein;
>
> D. Allow the Secretary, plaintiffs and plaintiffs-in-intervention to present expert testimony and other evidence to the court regarding the legal sufficiency of the Secretary's proposed survey system prior to the implementation date for the system in January 1986;
>
> E. Allow any other interested amicus designated by the court to comment on the proposed survey system; and

> F. On the basis of the court's own review of the Secretary's proposed survey system and evidence presented at the review proceeding, rule prior to the January 1986 implementation date whether the Secretary's proposed survey system complies with her statutory obligation and the mandate of the Tenth Circuit.

(Plaintiffs' and Plaintiffs-in-Intervention's Response to Secretary's Plan, pp. 1-2).

The plaintiffs and plaintiffs in intervention argue that the Secretary's Plan is insufficient for several reasons. First, they argue that the Plan cannot support the implementation of a new survey process absent court review and a public rule making process consistent with the Administrative Procedure Act ("APA"). They assert that this is so because the Plan provides no meaningful description of the proposed survey process and no definition of an "outcome-oriented" system, and depending on its definition, an "outcome oriented" system may or may not comply with the Tenth Circuit's mandate. They also assert that the Plan, by providing no judicial review of the survey process to be implemented in January, 1986, excludes the plaintiffs, the plaintiff class, and the plaintiffs in intervention from having any input into the ultimate remedy. The plaintiffs claim that the Plan violates the APA because any public input will be after the proposed survey process has been implemented, and that the Secretary's proposed target dates are illusory, because the key dates contain conditions, the occurrence of which will permit the Secretary to revise the plan.

Second, the plaintiffs argue that the Secretary's Plan and the failure of HHS to implement the required type of survey system during the past ten years require court intervention to protect nursing home residents and to bring survey system into compliance with the mandate of the Tenth Circuit. Third, the plaintiffs argue that new evidence will be available this fall which could help the court determine "whether the survey system ultimately proposed by the Secretary is sound from a regulatory standpoint and meets the requirements of the Medicaid Act as articulated by the Tenth Circuit." (Plaintiffs' Response, p. 4).

In response, the Secretary argues that the "Order on Remand called only for a plan setting forth a procedure and timetable for developing new forms and regulations. It did not call for a description of the new forms and regulations in the Plan itself..." (Defendant's Opposition, p. 2;

emphasis in original). This argument is somewhat disingenuous, as the Secretary was ordered to specifically set forth the procedures and timetable as part of the "plan for action to be taken to perform the ... duty" prescribed by the Tenth Circuit. Second, the Secretary argues that the Order did not indicate that the Plan would provide a basis for judicial review of the substance of the proposed regulations and forms. This court did indicate, however, that it does not intend "to remain passive until some final agency action has been taken." In addition, the Secretary argues that this court's review of the Secretary's actions is limited to the administrative record, that discovery must be confined to the production of that record, and that the scope of this court's review precludes an evidentiary hearing.

The evidentiary hearing, discovery schedule, and review of the proposed regulations and forms prior to public rule making sought by the plaintiffs are beyond the authority of this court. "[O]rdinarily review of administrative decisions is to be confined to 'consideration of the decision of the agency ... and of the evidence on which it was based.' ... '[T]he focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court.'" Federal Power Commission v. Transcontinental Gas Pipe Line Corp., 423 U.S. 326, 331 (1976)(citations omitted). Furthermore, discovery in suits challenging an agency regulation "is usually limited to the administrative record that was before the agency when the final rule was adopted." Texas Steel Co. v. Donovan, 93 F.R.D. 619, 620-21 (N.D. Tex. 1982).

The plaintiffs argue that the court has equitable powers to establish a schedule for administrative action. This is different from reviewing the proposed regulations and forms. "The remanding court is vested with equity powers and, while it may not '[intrude] upon the administrative province, it may adjust its relief to the exigencies of the case in accordance with the equitable principles governing judicial action.'" Zambrana v. Califano, 651 F.2d 842, 844 (2nd Cir. 1981)(quoting Ford Motor Co. v. NLRB, 305 U.S. 364, 373 (1939)). As one of the court's equitable powers, it may set a time limit for administrative action. Id. See also, Englehart v. Schweiker, 558 F. Supp. 112 (D. S.D. 1983)(ordering the Secretary to conduct an expedited de novo hearing following a decision to discontinue disability payments); Natural Resources Defense Council, Inc. v. Train, 510 F.2d 692 (D.C. Cir. 1974)(finding that the trial court acted reasonably in incorporating a publication schedule into its order that the EPA publish effluent limitation guidelines within one year to compel performance of the EPA's statutory duty).

The plaintiffs also cite Blankenship v. Secretary of Health & Human Services, 587 F.2d 329 (6th Cir. 1978) in support of their motion. In Blankenship, the plaintiffs challenged delays by the Social Security Administration in scheduling administrative hearings. The district court ordered the Secretary to schedule hearings within 90 days of application for a hearing. The Sixth Circuit Court of Appeals found that claimants had a right to a hearing in a "reasonable" time and that the judicially imposed 90-day time limit was not appropriate and was inconsistent with the principle of separation of powers. The court remanded the case to the district court with instructions to order the Secretary to develop regulations to remedy the problem of unreasonable delay and submit them to the district court for review of their reasonableness before publishing them as proposed or final regulations.

On remand, the district court established a discovery and briefing schedule on the issue of the reasonableness of the regulations proposed by the Secretary, while expressing considerable concern over the scope of the court's authority to review the matters before it. Blankenship v. Secretary of Health & Human Services, 522 F. Supp. 618 (W.D. Ky. 1981). The Sixth Circuit's affirmance of the time limitations eventually established by the district court was vacated and the case remanded to the district court for reconsideration in light of Heckler v. Day, ___ U.S. ___, 104 S. Ct. 2249, 2258 (1984)("[I]t would be an unwarranted judicial intrusion into this pervasively regulated area for federal courts to issue injunctions imposing deadlines with respect to future disability claims." Id. at 4641.)

This court does not have the authority to review the proposed regulations and forms prior to a public rule making process, and the motion of the plaintiffs and the plaintiffs in intervention for review proceedings must be denied. The court, however, restates its position that it will not sit passively by pending final agency action, particularly under the circumstances of this case where the Secretary proposes to completely implement a new survey process without any opportunity for public participation. The Secretary asserts that "while the Secretary's plan contemplates certain actions between now and the end of this calendar year, it contemplates final action in stages beginning in January 1986; and plaintiffs offer no cogent reason why final action or substantive review thereof should occur sooner." (Defendant's Opposition to Plaintiffs' Motion, p. 3; emphasis in original). Neither does the Secretary offer any compelling reason why a new survey system must be funded, implemented, and tested prior to any public rule making process.

This court was ordered to "compel" the Secretary to perform her prescribed duty. That duty was to "promulgate regulations which will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care." Estate of Smith v. Heckler, 747 F.2d at 591. As noted by the Tenth Circuit, the Secretary has broad discretion as to how to accomplish that duty. This court interprets that discretion as relating to the content of the proposed regulations. Accordingly, it is

ORDERED, that by October 31, 1985, the Secretary will develop and publish a notice of proposed rule making, consistent with the requirements of the APA, regarding a new survey system which will enable the Secretary to perform the duty prescribed by the Tenth Circuit Court of Appeals, and it is

FURTHER ORDERED, that the plaintiffs' application for attorneys' fees is denied and the motion of the plaintiffs and the plaintiffs in intervention for review proceedings is denied.

Dated: August 9, 1985

BY THE COURT:

Richard P. Matsch

Richard P. Matsch, Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 75-M-539

In re the Estate of:

MICHAEL PATRICK SMITH, et al.,

Plaintiffs,

and

PEOPLE OF THE STATE OF COLORADO, et al.,

Plaintiffs in Intervention,

v.

MARGARET M. HECKLER,
Secretary of Health and Human Services,

Defendant.

FILED
UNITED STATES DISTRICT COURT
DENVER, COLORADO

AUG 9 1985

JAMES R. MANSPEAKER
CLERK

MEMORANDUM OPINION AND ORDER

Because of the limitations expressed in the Memorandum Opinion and Order entered August 9, 1985, with respect to the plaintiffs' application for attorneys' fees and the motion of the plaintiffs and the plaintiffs in intervention for review proceedings, it is

ORDERED, that the motion of the American Health Care Association for leave to file a brief amicus curiae is denied.

Dated: August 9, 1985.

BY THE COURT:

Richard P. Matsch

Richard P. Matsch, Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 75-M-539

In Re The Estate Of:

MICHAEL PATRICK SMITH, et al.,

Plaintiff,

and

PEOPLE OF THE STATE OF COLORADO, et al.,

Plaintiffs In Intervention,

v.

MARGARET M. HECKLER, Secretary of Health
and Human Services,

Defendant.

MOTION TO ENJOIN RULEMAKING PROCEEDINGS

Plaintiffs and plaintiffs-in-intervention, by and through their counsel, move this court for an order permanently enjoining the "rulemaking proceeding" commenced by the Secretary of Health and Human Services with the publication on October 31, 1985 of the attached notice of proposed rulemaking (NPRM) regarding the long-term care survey for the Medicaid and Medicare program. Plaintiffs and plaintiffs-in-intervention further request that this court order the Secretary of Health and Human Services to:

A. Publish a new notice of proposed rulemaking which contains the actual rule by which the Secretary intends to implement the Department of Health and Human Services' proposed survey/certification system and the actual survey/certification forms, methods and procedures the Secretary intends to utilize to comply with the Tenth Circuit Court of Appeals mandate that she "promulgate regulations which will enable her to be informed as to whether nursing facilities receiving federal money are satisfying the requirement of the Medicaid Act," and "to ensure that states comply with the Congressional mandate to provide high quality medical care and rehabilitation services." 747 F.2d 583, 590-591; and

B. Allow, at a minimum, a 60 day comment period following publication in the Federal Register of the Secretary's actual proposed rule and the survey/certification forms, methods and procedures or the publication of the Institute of Medicine's study on the survey process, whichever is later.

As grounds for this motion, plaintiffs and plaintiffs-in-intervention state as follows:

1. On August 9, 1985, this court issued its order that the Secretary of Health and Human Services "develop and publish a notice of proposed rulemaking, consistent with the requirements of the APA, regarding a new survey system which will enable the Secretary to perform the duty described by the Tenth Circuit Court of Appeals." That duty, as described in this court's August 9, 1985 memorandum opinion and order, was to "promulgate regulations which will enable [the Secretary] to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care." August 9, 1985 order, p. 13.

2. The Secretary of Health and Human Services on October 31, 1985 published the attached notice of proposed rulemaking (NPRM).

3. The Secretary's NPRM on its face violates this court's August 9, 1985 order in the following specific regards:

a. The notice of proposed rulemaking contains only a description of two proposed rule changes which have absolutely nothing to do with enhancing the goal of ensuring high quality medical care and an eliptical description of a new system called the PaCS process which the Secretary intends to implement without regulations. In truth, the proposed rule changes are not changes at all, but simply a reaffirmation of existing regulations which mandate that state survey agencies must follow all federal forms, methods and procedures when certifying nursing facilities under the Medicaid and Medicare program. See 42 C.F.R. 442.30(a)(4) and 42 C.F.R. 431.610(f).

The actual change proposed by the Secretary is the mandating of the PaCS system. However, the Secretary does not include the PaCS survey forms and guidelines in the October 31, 1985 NPRM. Rather, the Secretary only notes that copies of the PaCS survey forms and guidelines can be secured by writing to HCFA in Baltimore, Maryland.

Although counsel for plaintiffs formally requested copies of the PaCS system on November 6, 1985, the first day the NPRM was available in the Colorado Supreme Court library, we have yet to receive such copies. Therefore, the public comment period outlined in the NPRM will not be a 60-day comment period but a substantially shorter one.

Further, the Secretary states in the NPRM that she does not plan to submit the PaCS survey system to formal rulemaking:

> Just as the forms and procedures of the current survey process are not set forth in the regulations, the new forms and procedures in any future changes can and will be implemented through general instructions without changing the regulations.

50 Fed. Reg. p. 45585. Even if one were to concede arguendo that the survey process should be subject to continuous improvements, the Secretary's failure to even publish the process for public comment raises the issue of whether the Secretary is making a good faith effort to comply with the mandate of the Tenth Circuit and this court's August 9, 1985 order.

b. The short 60-day comment period allowed by the October 31, 1985 NPRM also ensures that the public comment period will end and the administrative record closed before the issuance of the the Institute of Medicine's report on its 26 month study of the survey certification process. This $2 million Institution of Medicine study was commissioned by HHS as a result of an agreement between HHS and Congress that an outside evaluation of the survey process would be conducted before a new system was implemented unless otherwise ordered by a court of competent jurisdiction. On information and belief, the Institute of Medicine's study includes a review of the PaCS system and raises some fundamental issues regarding the system. This short public comment period will also ensure that the public will not have an opportunity to review the conclusions of the Institute of Medicine's report prior to submitting their own comments on the PaCS system.

Counsel for plaintiffs attempted to resolve with counsel for the Secretary these concerns regarding the short comment period and implementation of training prior to the end of the public rulemaking process. Specifically, plaintiffs requested that the comment period be extended until 60 days after the publication of the Institution of Medicine's study and that training be delayed until after a final rule is published. Counsel for the Secretary declined to raise these concerns with the Secretary, and simply said plaintiffs could send a letter to the Secretary with these requests.

c. The Secretary's description of the PaCS system in the October 31, 1985 NPRM on its face does not comply with the mandate of the Tenth Circuit. The system, according to the NPRM, simply provides "a better basis for judging the quality of care actually provided to patients because it gives greater emphasis to patient outcomes." 50 Fed. Reg. p. 45584. The Secretary does not even contend that her proposed system meets the mandate of the Tenth Circuit that the system be capable of continuously ensuring that Medicaid certified nursing homes actually provide high quality medical care and rehabilitative services to residents.

d. The Secretary's eliptical description of the PaCS system in the October 31, 1985 NPRM implies that the Secretary intends to implement, as a component of the survey certification system, self-surveying by nursing facilities certified under Medicaid and Medicare using the existing survey instrument. According to the NPRM:

> ...at the time of initial survey, the facility would be measured against all the items of the current survey form to ensure that it meets all participation requirements. At the time of resurvey, to determine whether continuing participation is justified, the facility would be required to sign a statement that it not only continues to meet these participation requirements, which are not directly assessed by the outcome oriented process, but that it agrees to notify the SA immediately if conditions in the facilities are so changed as to raise questions of whether it continues to comply with the participation requirements...

50 Fed. Reg. p. 45585. The use of the 1569 form which the Tenth Circuit found to be legally insufficient, as the basis for the initial certification under Medicaid and Medicare coupled with subsequent self-surveying by nursing facilities can only be considered deregulation and an abrogation of the Secretary's statutory duty.

4. The bogus nature of this "rulemaking proceeding" is further evidenced by the Secretary's persistence in scheduling and conducting training concerning the implementation of the PaCS system prior to the end of the public comment period. A training program for trainers on the PaCS system is scheduled for Baltimore, Maryland on December 10-11, 1985. Training materials on how to implement the PaCS system for this December 10-11, 1985 and for subsequent regional/state surveyor training has been finalized and approved by HHS and is at the printers. Therefore, it is clear that HHS is intending to implement the PaCS system largely in its present form without regard to any public comments it receives and without first obtaining this court's approval that the final rule meets the statutory mandate.

5. The October 31, 1985 NPRM at p. 45585 states that HHS convened a work group of representatives of consumer advocacy groups, state agencies and the nursing home industry "to identify what might be acceptable changes in the survey process" and then asserts that this work group

> gave unanimous support to the reforms embodied in the early version of PaCS...

This statement is a misrepresentation of fact. The major consumer advocacy organizations have all raised serious questions regarding the present primitive form of the PaCs system. In addition, the National Association of State Surveyors adopted on November 16, 1985 a unanimous resolution declaring that the PaCS system in its present form is not supported by state licensure directors without the following changes:

a. Inclusion of a patient assessment process;

b. Development of a statistically valid sampling methodology;

c. Consideration of the Institute of Medicine's findings;

d. Development of guidelines and standards for implementation of the PaCS system; and

e. Adequate training of survey staff.

6. Given the Secretary's previously listed disingenuousness and now open defiance of this court's prior orders, this court must intervene in the existing rulemaking proceeding to ensure that the Secretary renders the performance to which plaintiffs and the public are entitled. National Resources Defense Council, Inc. v. Train, 510 F.2d 692, 705 (D.C. Cir. 1975). Consistent and open defiance of statutory mandates and court orders on issues of great public importance constitute extraordinary circumstances which require that this court impose a remedy that permits nursing home residents to obtain high quality care without delay. Pulido v. Heckler, 758 F.2d 503 (10th Cir. 1985); McCullough Gas Processing v. Department of Energy, 650 F.2d 1216, 1230 (10th Cir. 1981). This court may act "so as to afford full justice to all the real parties in interest." Porter v. Warner Holding Co., 328 U.S. 395, 398 (1946).

When this court entered its August 9, 1985 order, it deferred to the administrative discretion of the Secretary of Health and Human Services and gave her an opportunity to use the public rulemaking process to develop rules which would comply with the Tenth Circuit mandate. The Secretary, by her promulgation of the October 31, 1985 NPRM, has clearly signaled her intent to ignore the Tenth Circuit's mandate and this court's order. Therefore, this court may no longer remain passive, but must actively intervene to ensure a fair rulemaking process.

Based upon the foregoing reasons, plaintiffs and plaintiffs-in-intervention respectfully request that the court set a forthwith hearing on this motion and thereafter enjoin the current rulemaking process; direct the Secretary to publish in the Federal Register the PaCS system she intends to implement; allow a 60-day notice and comment period following publication of the PaCS system and/or the publication of the Institute of Medicine study; and order the Secretary to turn over to plaintiffs' counsel any documents within her possession relating to the PaCS system within ten days of this court's order.

Respectfully submitted,

LAW OFFICE OF KATHLEEN MULLEN, P.C.

Manuel O Ramos for KM
By: Kathleen Mullen, #8707
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ATTORNEYS FOR PLAINTIFFS

OFFICE OF THE ATTORNEY GENERAL

By: Maurice Knaizer
Assistant Attorney general
1525 Sherman Street
Denver, Colorado 80203

ATTORNEY FOR PLAINTIFFS-IN-INTERVENTION

I certify that I have sent a true and correct copy of the foregoing Motion to Enjoin Rulemaking Proceedings this 26th day of November, 1985, to:

Shalom Brilliant
Sandra M. Schraibman
U.S. Department of Justice
Civil Division, Room 3324
10th & Pennsylvania, N.W.
Washington, D.C. 20530

Janis E. Champman
Assistant U.S. Attorney
1200 Federal Office Building
1961 Stout Street
Denver, Colorado 80294

Vicki Shulkin
Office of General Counsel
Department of Health and
Human services
330 Independence Ave., S.W.
Washington, D.C. 20201

Trish Nemori
Toby Edelman
National Senior Citizens Law Center
2025 M Street, N.W., Suite 400
Washington, D.C. 20036

Teresa G. Duncan

December 27, 1985

Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-119-P
P.O. Box 26676
Baltimore, Maryland 21207

Plaintiffs and Plaintiffs-In-Intervention in Smith v. Heckler Comments and Response to Health Care Financing Administration Proposed Rules, October 31, 1985, Federal Register, Vol. 50, No. 211, File Code: HSQ-119-P

On October 29, 1984, the Tenth Circuit Court of Appeals held in Smith v. Heckler, 747 F.2d 583 that:

> The Secretary of Health and Human Services has a duty to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act, including providing high quality patient care. The duty to be adequately informed is not only a duty to be informed at the time a facility is originally certified but also a duty of continued supervision.

Because "in fact the quality of care provided to the aged is the focus of the Act," the Court also held with respect to the existing survey/certification system in effect since 1974 that:

> We must conclude that a failure to promulgate regulations that allow the Secretary to remain informed, on a continuing basis, as to whether the facilities receiving federal monies are meeting the requirements of the Act, is an abdication of the Secretary's duty.

Further the Court held that because:

> the purpose and focus of the Act is to provide high quality care by promulgating a facility oriented system, the Secretary has failed to follow that focus and such failure is arbitrary and capricious.

To remedy the Secretary's abdication of her duty the Court issued a mandamus order compelling the Secretary to promulgate regulations which both "ensure that states comply with the congressional mandate to provide high quality medical care and rehabilitative services," and ensure that the Secretary is herself continuously informed "as to whether the nursing home facilities receiving Medicaid funds are actually providing high quality medical care."

It is against these orders and legal standards that the Departments PaCS proposal must be judged. Plaintiffs and Plaintiffs-in-Intervention are convinced that the current proposal falls far short of achieving the statutory duty of the Secretary as determined by the 10th Circuit Court of Appeals in its Final Judgment. Our concerns are not only substantive. They are also procedural.

The Secretary's Rulemaking Procedure is Defective

For the reasons stated in our recently filed Motion to Enjoin Rulemaking Procedure, before promulgating the remedy in this case, the Secretary should first publish in the Federal Register the PaCS system she intends to implement. Thereafter, the public should be afforded a 60-day notice and comment period following publication of the PaCS system. The short comment period allowed by the October 31, 1985 NPRM ensures that the public comment period will end and the administrative record is closed before the issuance of the Institute of Medicine's Comprehensive Report on Improving the Quality of Care in Nursing Homes. This report is not due out until February. See the attached affidavit from David Tilsin. A copy of our Motion to Enjoin Rulemaking Proceedings together with our Supplemental Data in Support of Motion to Enjoin Rulemaking Proceedings is attached hereto and incorporated herein by reference.

The request for an extension of time as set forth in the attached Motion to Enjoin Rulemaking Proceedings is unanimously supported by the participants in the NCCNHR Work Sessions and the NCCNHR Board of Directors in their comments to HCFA regarding these proposed rules. Likewise, the Association of Health Facilities Licensure and Certification Directors on December 4, 1985 informed the HCFA Administrator in writing that they unanimously supported the procedural points Plaintiffs raised in their Motion to Enjoin Rulemaking Proceedings. This organization of all state survey/certification inspectors also supports Plaintiffs' substantive recommendations as set forth below.

It was not until after we filed our Motion to Enjoin Rulemaking Proceedings that the Department printed its Care Guidelines for OIRR. These guidelines which are substantively commented upon below were not even distributed until December 9, 1985. Although they appear to be the "guts" of the Department's proposal, on information and belief, they are not being distributed to persons requesting rule related materials prior to

December 6, 1985. On December 9, 1985, they were passed out for the first time to a select group at the NCCNHR Work Session.

As was shown at trial in this case, in 1974 when the current system was promulgated, HEW also knowingly ignored the results of its own research. In 1973, HEW published Patient Classification for Long term Care: User's Manual. This document summarized the research efforts in patient assessment and care evaluation from 1949-1973. It also provided a "patient classification system which had been tested for validity and reliability." HEW itself declared that this system was capable of use in evaluating care actually delivered to long term care patients. Instead of utilizing this research in 1974, the Department promulgated the now invalidated facility oriented survey system, and supplied to the states a number of federal survey forms which the states were forced to utilize in performing inspections together with a manual to guide state surveyors in completing the federal forms.

The National Institute of Medicine was requested by the Department of Health and Human Services in 1982 to address a congressionally perceived crisis in federal regulatory efforts. The NIM study was preceded by a congressionally imposed moratorium on rulemaking by the Department which was then actively attempting deregulation of nursing homes. As in 1974, it appears that the Department is again determined to ignore the results of research it has commissioned at great public expense. We submit it is utterly unconscionable for the Department to close its rulemaking record before receiving the Institute of Medicine Report. This report must be made a part of the record of proceedings on the proposed rule. It must also be carefully considered and the PaCS proposal reviewed in the light of its comments thereon and on all related enforcement issues. Further, the public must be permitted to study this report and submit further comments for HCFA's consideration before final promulgation and implementation of the PaCS system at the administrative level.

By submitting comments at this time, plaintiffs are not waiving or in any way abandoning their position as stated in the attached Motion to Enjoin Rulemaking Proceedings. The Court has not yet ruled on the motion and the comment period may expire before it does.

Substantive Comments Regarding PaCS

1. Attached hereto is the Motion for Remedy which we have filed with the District Court since the ruling of the 10th Circuit Court of Appeals outlined above. In this document, we proposed that the Secretary provide a detailed description of the procedures she will require skilled nursing and intermediate care facilities to use and the survey/certification forms, methods, interpretive guidelines and procedures to be used by the state survey agencies in conducting inspections to assure that:

-- Upon entrance into the facility and at reasonable intervals thereafter each Medicaid resident's needs for rehabilitative, nursing, psychosocial and medical care are comprehensively and appropriately assessed;

-- An appropriate interdiscipilinary plan of care based upon these needs is developed and implemented;

-- Each resident's progress under the care plan is continuously assessed;

- -- The care plan is revised and updated as the needs of the resident change; and
- -- High quality care appropriate to the resident's needs is actually provided.

We also suggested that the Secretary in developing the new certification process specifically answered each of the questions stated in A-M on pages 3 and 4 of the attached Motion for Remedy.

It is our position that the PaCS proposal utterly fails to address almost all of these issues in any adequate fashion. It is also our position that while the answers to each of these questions might involve choices between reasonable alternatives, _no_ sufficient system capable of complying with the mandate of the 10th Circuit can be developed without satisfactorily addressing each of these questions and the items quoted directly above. We urge the Department to carefully consider and adequately answer each of these A-M questions and items in the attached Motion for Remedy before promulgating any final rule. The nation has suffered for 10 years from the previous abdication of duty by the Secretary. Now the necessary time must be taken to fulfill the Secretary's duty in a legal manner.

2. Of immediate concern is the fact that the Secretary in PaCS has utterly failed to ensure that facility-staff and state surveyors will utilize appropriate long term care data and definitions in the resident care management and enforcement inspection processes. There appears to be no means in PaCS for assuring that the care provided to Medicaid nursing home patients is appropriately and uniformly assessed. No type of uniform

facility assessment instrument has been proposed and the Secretary has not developed a system in the absence of such a form to assure appropriate assessments of residents' needs and care plans commensurate therewith are developed and implemented in the nation's nursing homes. There also isn't any method defined for imposing sanctions even if PaCS identifies care problems; there are no criteria or standards as to the sanctions that should be applied. HCFA should promulgate intermediate sanctions as discussed by the IOM committees.

3. PaCS is also apparently to be promulgated without changing any of the conditions and standards. These remain facility-oriented and do not include quality of life factors. Major changes are necessary in the conditions and standards to make them much more overtly resident and outcome oriented before a truly effective survey process can be designed and put into place. We urge the Department to carefully review and then repropose the July 14, 1980 Patient Care Management System Regulation it published in the Federal Register and subsequently filed with the Court. Please carefully review 45 Fed. Reg. 47368, Trial Exhibit 222. We urge the Department to return to this proposed rule as a necessary basis for the reform of the survey/certification process. We also suggest that the Department consider the recommendations of the IOM as bearing on the necessity for a patient care assessment system before proposing the same and include these recommendations in any subsequent proposal.

We further urge the Department to return to the premises stated in the Stipulation which we reached with the Secretary of HHS in response to the July, 1980 notice of proposed rulemaking. A copy of the text of this Stipulation is attached hereto for ready reference.

The stipulation provided that as "a major part of the survey certification system" inspectors would:

> examine a randomly selected representative sample of patients to validate the adequacy and appropriateness of the facility's comprehensive assessment process, and its care and discharge plans, with respect to such persons, and to determine by directly reviewing the actual conditions and needs of the residents assessed whether, in fact, the facility is providing needed and required care of an acceptable quality to its patients. . .

Because the PaCS does not and cannot do this, it is insufficient to assure the achievement of the duty of the Secretary as ordered by the 10th Circuit. Just as was the case with the system which the Court invalidated, the PaCS guidelines direct the surveyors attention towards the subject matter of patient care but provide no mechanism or place for the systematic and reliable gathering and reporting of patient care findings. Likewise, no standards are set forth in the proposal for determining whether a given condition is out of compliance. No criteria for making such judgments are even proposed.

The criteria for selecting patients for intensive review leave the actual selection dependent on the individual survey's judgment. This means inevitably that there will be great variation among surveyors and therefore in the application of survey procedures among nursing homes as to the proportion and types of patients selected. These subjective sampling procedures do not allow for an overall estimate of the nursing home's performance in providing appropriate care nor for a comparison of the nursing homes in this regard.

PaCS does not contain any methodology or protocol for sampling of residents for in depth reviews of care giving. There appears to be no requirement of stratification by case mix or any recognition of the requirements of statistically valid sampling. The Department developed and described such a methodology in its July, 1975 "Long Term Care Improvement Campaign: Introductory Report." This methodology was utilized by HEW to conduct a survey of the quality of care in the nation's nursing home. It should be carefully reviewed and built upon to solve this fundamental problem with PaCS.

The necessity for inclusion of uniform data and definitions is so obvious to us that we are astonished that PaCS utterly fails to employ or require any standard terminology of patient status and nursing home plans of care. Unless there is a standard requirement as to the items of information, including definitions, that are to be incorporated in the nursing home patients records as well as in the surveyor's instruments and guidelines, the review of this information will be tedious and hopelessly dependent on surveyor's interpretation. More importantly, the resulting system will be invalid, unreliable, utterly subjective and non-reproducible. Any reasonable quality assurance system must require a standard resident assessment data base both for tracking case mix and for determining changes in residents outcomes. For the same reason, we have urged earlier the Department must add a resident assessment procedure as a Condition of Participation. This was clearly also the Department's understanding of the problem in 1980 when the NPRM was published and the Stipulation signed. We suggest that the Department again study the "Long Term Health Care, Minimum Data Set, Report of the Technical Consultant Panel on the Long-Term Health Care Data Set as submitted to the National Committee on Vital and Health Statistics in July, 1979. This Department document was the tandem document to the PACE project and together with the Patient Classification for Long Term Care: Users Manual published by the Department in 1973 provides the basis for the Department's issuance of common data and definitions for the care management and survey processes. We urge the Department to incorporate this basic reform into its proposed PaCS system.

4. PaCS does not, but must, integrate its surveys with the inspection of care function. Also appropriate funding must be assured in the face of such changes. IOC must be merged with a resident centered outcome survey process to avoid duplication. Properly developed, PaCS could become the standard survey protocol that is needed. Unfortunately, as currently proposed it is not even analytically or conceptually a part of an overall reform of the regulatory system governing the nursing home industry. It does not incorporate other fundamental changes in nursing home performance guidelines, in the survey certification process or in the enforcement system that are necessary to make any significant advances in the regulatory system.

5. PaCS with its self selecting focus on bad outcomes is really not much more than a more sophisticated detection device for scandalously poor care or custodial care. It is not designed nor intended to assess the needs and adequacy-of-care plans for the average non-abused nursing home resident. It is not calculated to permit an audit which is actually designed to determine whether the average patient, randomly selected according to appropriate sampling and case mix criteria, is actually receiving his/her statutory entitlements to high quality medical psychosocial, rehabilitative and nursing care to the end that each such person be permitted the opportunity to attain or retain his or her optimal capacity for self care and independence. Thus, it is not aimed at the achievement of the statutory purpose. As the Department put it in February, 1976, "it is time to put the patient first." Legally, this can only be done by a systematic inspection system which is oriented to the statutory duty as stated by the 10th Circuit. As the court expressed it, this duty is to:

> provide both medical assistance to aged, blind, or disabled individuals whose means and resources are insufficient to meet the costs of necessary medical services to help such individuals attain or retain capabilities for independence or self care.

The proposals the Department made in 1980 and the research that it conducted from 1973 to 1980 were focused on the achievement of this unchanged statutory purpose. The PaCS system is not so focused and unless the revisions suggested herein are incorporated and the questions herein posed are answered, it cannot discharge the Secretary's duty as defined by the 10th Circuit.

Respectfully submitted,

Kathleen Mullen

John Holland
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Smith v. Heckler, Civil Action No. 75-17-539 (D. Colo., filed 1975)

May 16, 1975: Two nursing home residents file a class action suit against their nursing home and the federal and state governments. They complain that the federal enforcement system fails to ensure that residents are receiving their Medicaid entitlement to optimal medical and psychosocial care in a safe, sanitary, rehabilitatively supportive, accessible and personalized environment and in a context of full civil liberties.

1976 and 1977: Judicial decision is deferred while an effort is made to establish a fact-finding methodology for surveying conditions in Colorado facilities. That effort fails.

1978: Plaintiffs dismiss the State of Colorado as a defendant; the state intervenes and becomes a plaintiff.

April 4, 1978: The court certifies a statewide class of all Medicaid recipients in Colorado nursing homes.

August 6, 1980: Plaintiffs, the state and the federal defendants file a joint motion for a stay, based on proposed regulatory revisions to the federal Conditions of Participation published on July 14, 1980.

The proposed regulations are never published in final form.

May 17 - June 4, 1982: A trial against the federal government is conducted.

February 8, 1983: The federal district court issues a decision, ruling against plaintiffs. Smith v. O'Hallorhan, 557 F. Supp. 289 (D.Colo. 1983). The court holds that while the evidence clearly showed that it is "feasible" for the Secretary

> to require the use of a patient care management system which would control the assessment of patient needs, facilitate the development of an appropriate patient care plan, provide the mechanism for monitoring the delivery of care by the facility itself and by the state review teams, give SSA the means for validating the state reports, and probably improve the quality of health care services provided for all Medicaid recipients

557 F. Supp., at 295, the Secretary's failure to introduce and require the use of such a system is not a violation of any statutory duty. According to the court, the state is responsible for survey and certification activities.

October 29, 1984: The Court of Appeals reverses the federal district court. Smith v. Heckler, 747 F.2d 583 (10th Cir. 1984). The court rules that the Secretary of HHS "has more than a passive role in handing out money to the states" but "has a duty to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act, including providing high quality patient care." 747 F.2d, at 589. The court finds that the Secretary has entirely failed to carry out her statutory duty "to promulgate regulations which will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care," id., at 591, and remands (sends back) the case to the district court to compel performance of the duty.

January 31, 1985: Plaintiffs file papers requesting that the court, at the February 13, 1985 status conference, order HHS to begin implementing the Court of Appeals decision. They ask the court (1) to order HHS to file a written plan of compliance within 60 days, (2) to allow them 30 days to file a written response, (3) to set a hearing within 60 days, and (4) to retain jurisdiction until HHS has promulgated and implemented a resident care oriented nursing home enforcement system.

April 29, 1985: The court issues an Order on Remand, requiring the Secretary to file a plan for action by June 10, 1985.

May 9, 1985: The American Health Care Association files a motion to be an amicus in the case.

May 20, 1985: HHS opposes AHCA's motion.

June 10, 1985: HHS files a Plan of Action, which sets out a timetable for implementing a revised survey process. HHS proposes to test the outcome-oriented survey process, evaluate and revise it (10/31/85) to get HHS approval of all survey forms and procedures (11/1/85), to train surveyors in the new process (12/15/85), to obtain approval from the Office of Management and Budget (12/30/85), to revise State Operations and Regional Office Manuals (12/31/85), and to implement new procedures to require States survey agencies to use the forms, etc. (1/86). HHS proposes "after new procedures have been given final [sic] approval," to publish proposed regulations with a 60-day comment period (3/15/86) and to publish final regulations (8/15/86).

June 19, 1985: Plaintiffs and Colorado oppose HHS' Plan of Action. They ask for an evidentiary hearing in November, 1985 to determine whether the Secretary's proposed survey process "has even the threshhold potential for complying" with... the Secretary's statutory duty. They propose an alternative timetable.

August 9, 1985: The federal district court orders the Secretary of HHS to develop and publish, by October 31, 1985, proposed regulations enabling her to be informed whether nursing homes provide high quality care. The court denies plaintiffs' motion for review proceedings and the motion of the American Health Care Association to file an amicus brief.

August 28, 1985

Toby Edelman

NCCNHR Note: On November 20th, 1985, Attorneys for Plaintiffs (Mullen, Holland and Knaizer) filed a "Motion to Enjoin Rulemaking Proceedings" in the U.S. District Court for the District of Colorado. (Copy attached.)

NCCNHR has been advised that the court hearing on this motion will be held on Thursday, December 12, 1985.

UNITED STATES DISTRICT COURT DISTRICT OF COLORADO Civil Action No. 75-M-539

NOTICE OF PROPOSED SETTLEMENT OF CLASS ACTION NURSING HOME LAWSUITS AGAINST BIRCHWOOD PAVILION CARE CENTER AND HERITAGE HOUSE NURSING CENTER

In Re the Estate of MICHAEL PATRICK SMITH, et.al., Plaintiffs, v. THOMAS J. O'HALLORAN, et.al., Defendants.

You are hereby notified of a proposed settlement of this class action, of a hearing to be held by the Court to determine whether it should be approved, and of what you must do now if you were either a Medicare or Medicaid certified resident of Birchwood Pavilion Care Center or Heritage House Nursing Center located at 5301 West First Avenuee, Lakewood, Colorado during any part of the period between January 1, 1973 and March 1, 1978 and if you believe that you have a claim for damages against these nursing homes due to substandard nursing home care.

This Court, for settlement purposes only, has certified a settlement class consisting of all living persons who were Medicaid or Medicare certified and who resided in either Birchwood Pavilion Care Center or Heritage House Nursing Center between January 1, 1973 and March 1, 1978.

The lawsuit seeks damages against these nursing homes and their individual owners based upon allegations by individual residents (plaintiffs) that Heritage House Nursing Center and Birchwood Pavilion Care Center failed to provide the high quality care required by the Medicare and Medicaid Act. but instead provided substandard care. Plaintiffs also allege that those nursing homes were grossly negligent and constituted a public and private nuisance.

Defendants have denied any liability or wrongdoing.

The attorneys for the class representatives and the attorneys for all of the defendants have entered into a settlement agreement, made as of September 15, 1986, which is subject to and conditioned upon the final Court's approval of its terms. Under the settlement, if it is approved, the defendants collectively will pay $2,250,000 into a settlement fund to be established and supervised by the Court for the payment of plaintiffs' and class members' claims. Plaintiffs' counsel is seeking $291,667 from the class claimants' portion of this fund as attorneys' fees and costs. In addition, plaintiffs' counsel, pursuant to their contingency retainer agreements with the individual plaintiffs, will receive one-third of the funds ordered to these individuals.

The settlement fund will be distributed between plaintiffs and class claimants as follows

A. Individual awards to plaintiffs	$1,375,000
B. Class fund reserved for settlement class claimants.	$875,000

Awards to settlement class claimants will be made according to a formula set out in the settlement agreement and based upon the following criteria:

A. Claimant was subjected to a substandard physical environment and/or had his/her personal needs money mismanaged.

B. Claimant was subjected to a substandard physical environment and received inadequate rehabilitative care necessary to meet his/her individual psycho/social needs.

C. Claimant was subjected to a substandard physical environment and received inadequate rehabilitative care necessary to meet his/her individual psycho/social needs, and
Was subjected to neglect of his or her elementary physical needs or received inadequate medical/nursing care resulting in moderate physical injury.

D. Claimant was subjected to a substandard physical environmental and received inadequate rehabilitative care necessary to meet his/her individual psycho/social needs, and
Was subjected to total neglect of his/her elementary physical needs or received substandard medical/nursing care resulting in serious physical injury.

E. Claimant was subjected to a substandard physical environment and received inadequate rehabilitative care necessary to meet his/her individual psycho/social needs, and
Was subjected to substandard medical/nursing care over a prolonged period resulting in severe physical and severe emotional injury,

F. Claimant was subjected to a substandard physical environment and received inadequate rehabilitative care necessary to meet his/her individual psycho/social needs, and
Was subjected to substandard medical/nursing care or deliberate abuse resulting in life threatening, catastrophic injury.

The initial evaluation of class members' claims will be conducted by plaintiffs' counsel who, based upon the quality of evidence available to prove damages and the severity of both the alleged unlawful treatment and injuries resulting from such treatment, will present their damage award recommendations for each claimant to such claimant and, subject to any objection by such claimant and/or his/her representative, to this Court for approval. The same criteria were applied to the 22 individual plaintiffs' claims by plaintiffs' counsel in arriving at the recommended damage awards for these individuals.

Plaintiffs' counsel shall have 30 days from November 10, 1986 to evaluate the settlement class claimants' claims and determine whether the settlement fund is sufficient to cover these claims. If the total dollar value of the claims of settlement class claimants, based upon the formula outlined above exceed the amount reserved for such claims, plaintiffs' counsel shall give notice of such fact to plaintiffs, class claimants and to defendants' counsel by December 10, 1986. Further negotiation among the parties will commence immediately upon such notice and continue for not more than 10 days, at which time the parties shall either submit to the Court a revised settlement proposal which will resolve all of the claims or notify the Court that a settlement is not possible at this juncture of the litigation. Such negotiation efforts may include augmentation of the settlement fund and/or reallocation of the settlement fund among plaintiffs and class claimants. If such settlement efforts fail, the litigation will resume and all pending discovery responses and class certification motions will become due within 20 days of such notification to the Court.

Similarly, defendants have reserved the right to withdraw from this settlement if a class member or class members with substantial and material claims against the defendant exclude themselves from the class.

If the recommended claims for the settlement class members total an amount less than $875,000 plus the Court approved attorneys' fees, an amount up to $300,000, after all claimants' recommended class claims have been paid, shall be placed into a rehabilitative care fund to be administered by the Atlantis Community. Proceeds from this fund may be used to purchase durable medical equipment or rehabilitative therapy for any Colorado Medicaid or Medicare certified long-term care recipient. If any funds remain in the settlement class fund after all recommended class claims have been paid, attorneys' fees deducted and the rehabilitative care fund is established, these funds shall be distributed to plaintiffs and settlement class claimants on a prorated percentage basis.

Neither the settlement agreement, the distribution of the fund, nor the award of attorneys' fees will become effective unless and until the Court decides that the settlement should be finally approved as a fair, reasonable, and an adequate compromise of the claims of the settlement class as a whole. In order to assist the Court in making this decision, the Court will hold a hearing on December 26, 1986 at the following location: Courtroom A-2nd floor, Post Office Building, 18th & Stout Street.

The hearing will begin at 9:00 a.m. Any class member or his/her representative may raise any objection he or she may have to the proposed settlement or attorneys' fees at this hearing. Written objections to the settlement must also be submitted to the Clerk of the Court on or before November 10, 1986, at the address given at the end of this Notice.

If you do not want your claims to be covered by this lawsuit, you may request that the Court exclude you from the class provided that you make such request in writing, postmarked on or before November 10, 1986. Requests for exclusion should be mailed to:

James R. Manspeaker
United States District Court
Post Office Box 2204
Denver, Colorado 80201-2204

Said exclusion request should state as follows:

The undersigned hereby requests to be excluded from the class in the Smith litigation, 75-M-539.

The person requesting exclusion should sign the request. The request for exclusion shall not be effective unless it is made in the manner and within the time frame set forth in this notice.

If you request exclusion, you will not be bound by the judgment entered by the Court approving settlement, but you will also not be entitled to share in any class settlement fund established by such settlement.

Further, in an effort to determine as soon as possible the current number and nature of the claims to be made by class members, the Court requests that you follow the procedures outlined below. **If you wish to apply for compensation from the settlement fund for injuries you incurred as a result of residing at Heritage House Nursing Center or Birchwood Pavilion Care Center during the period January 1, 1973 through March 1, 1978, you must complete and mail a claim form (which you may obtain as indicated below) postmarked on or before November 10, 1986. If you fail to file such a claim form postmarked on or before November 10, 1986, you will be barred from making any claim for any damages relating to your residing at Heritage House or Birchwood Pavilon Care Center during any part of the period between January 1, 1973 and March 1, 1978.**

In order to obtain further information about the settlement, including a copy of the settlement agreement, and a claim form, call either 860-1331 (John Holland) or 329-9600 (Kathleen Mullen), or write to these attorneys at the addresses listed below:

John R. Holland
1490 Lafayette Street, # 202-A
Denver, Colorado 80218
Telephone: 860-1331

Kathleen Mullen
1750 Gilpin Street
Denver, Colorado 80218
Telephone: 329-9600

DATED this 15th day of SEPTEMBER 1986.

JAMES R. MANSPEAKER
Clerk of the United States District Court

APPENDIX 5

STATE NURSING HOME RECEIVERSHIP STATUTES

Ariz. Rev. Stat § 36-429

strict admissions and terminate specific services, procedures, practices or facilities may, at any time within thirty days after notice of such denial or order, request in writing a hearing before the director, to be held within thirty days following such written request, for the purpose of reviewing the action of the director.

C. All hearings shall be in accordance with title 41, chapter 6.

Added Laws 1971, Ch. 196, § 2, eff. Jan. 1, 1972. As amended Laws 1973, Ch. 158, § 78.

[1] Section 41-1001 et seq.

Historical Note

For the effective date of Laws 1973, Ch. 158, see Historical Note preceding section 36-101.

Cross References

Denial, suspension and revocation of license by department of health services, hearing, see § 36-443.

§ 36-429. Removal of licensee; continued operation

A. In addition to other remedies provided by this chapter, the director may, if he reasonably believes a violation of this chapter by a licensee endangers the health, safety or welfare of the patients of such licensee, bring an action requesting the superior court to:

1. Remove the administrative officers, agents or employees of such licensee by injunction, until such violation ceases.

2. Appoint temporary personnel to continue operation of such health care institution under conditions and requirements set by the court pending correction of the violation, restoration of the licensee or revocation of the license.

B. The action shall be brought in the name of the people of the state through the attorney general in the superior court in the county in which the health care institution is located.

Added Laws 1971, Ch. 196, § 2, eff. Jan. 1, 1972. As amended Laws 1973, Ch. 158, § 79.

Historical Note

Prior Laws:

Laws 1958, Ch. 52, § 5.
Laws 1962, Ch. 3, § 6.
A.R.S. former § 36-446.

For the effective date of Laws 1973, Ch. 158, see Historical Note preceding section 36-101.

Library References

Licenses 🔑21.

C.J.S. Licenses § 37.

California

§ 36-430. Unlicensed operation prohibited; injunction

The operation or maintenance of a health care institution which does not hold a current and valid license or which exceeds the range of the services authorized by the class or subclass for which it is li-

ARTICLE 8

Management of Long-Term Health Care Facilities

[Added by Stats 1982 ch 1456 § 2.]

§ 1325. Appointment of receiver

§ 1326. "Long-term health care facility"

§ 1327. Petition for order appointing receiver; Hearing; Determination; Bond; Notice

§ 1328. Liability

§ 1329. Powers and duties of receiver; Payment to receiver; Obligation and liability of licensee; Order of court for payment

§ 1329.5. Criteria for dishonor of lease, mortgage, secured transaction or contract

§ 1330. Monthly accounting

§ 1331. Duration of receiver's management; Termination; Sale, lease, or closure of facility

§ 1332. Salary of receiver

§ 1333. State funds

§ 1334. Right to dispose of property interest in facility

§ 1335. Authority of state department

§ 1325. Appointment of receiver

The Legislature finds and declares that the transfer trauma which accompanies the abrupt and involuntary transfer of frail elderly patients from one nursing home to another should be avoided when reasonable alternatives exist.

It is the intent of the Legislature in enacting this article to provide an alternative by establishing a system whereby the State Department of Health Services may apply for a court order appointing a receiver to temporarily operate a long-term health care facility. The receivership is not intended to punish a licensee or to replace attempts to secure cooperative action to protect the patients' health and security. The receivership is intended to protect the patients in the absence of other reasonably available alternatives.

The receiver may be appointed when a long-term health care facility is found to be in such condition that continued operation by the licensee, or his or her representative, presents a substantial probability or imminent danger of serious physical harm or death to the patients.

The receiver shall assume the operation of such a facility in order to either bring it into compliance with law and return it to the original licensee in accordance with standards set forth in this article, or facilitate a transfer of ownership to a new licensee. The receiver shall assure the orderly transfer of patients should the facility ultimately close.

Added Stats 1982 ch 1456 § 2.

§ 1326. "Long-term health care facility"

As used in this article, "long-term health care facility" means any skilled nursing facility or intermediate care facility licensed pursuant to this chapter.

Added Stats 1982 ch 1456 § 2.

§ 1327. Petition for order appointing receiver; Hearing; Determination; Bond; Notice

Whenever circumstances exist indicating that continued management of a long-term health care facility by the current licensee would present a substantial probability or imminent danger of serious physical harm or death to the patients, or there exists in the facility a condition in substantial violation of this chapter or the rules and regulations adopted pursuant to this chapter, or the facility exhibits a pattern or practice of habitual violation of this chapter or the rules and regulations adopted pursuant thereto, or the facility is closing or intends to terminate operation as a licensed long-term health care facility and adequate arrangements for relocation of residents have not been made at least 30 days prior to the closing or termination, the director may petition the superior court for the county in which the long-term health care facility is located for an order appointing a receiver to temporarily operate the long-term health care facility in accordance with this article.

The petition shall allege the facts upon which the action is based and shall be supported by an affidavit of the director. A copy of the petition and affidavits, together with an order to appear and show cause why temporary authority to operate the long-term health care facility should not be vested in a receiver pursuant to this article, shall be delivered to the licensee, administrator, or a responsible person at the facility to the attention of the licensee and administrator. The order shall specify a hearing date, which shall be not less than five, nor more than 10, days following delivery of the petition and order upon the licensee, except that the court may shorten or lengthen the time upon a showing of just cause.

At the time of the hearing, the state department shall advise the licensee of the name of the proposed receiver. The receiver shall be a licensed nursing home administrator or other responsible person or entity, as determined by the court, and shall have sufficient background and experience in management and finances to ensure compliance with orders issued by the court. The owner, licensee, or administrator shall not be appointed as the receiver unless authorized by the court.

If at the conclusion of the hearing, which may include oral testimony and cross-examination at the option of any party, the court determines that adequate grounds exist for the appointment of a receiver and that there is no other reasonably available remedy to protect the patients, the court may issue an order appointing a receiver to temporarily operate the long-term health care facility and enjoining the licensee from interfering with the receiver in the conduct of his or her duties. The court shall in any such proceedings make written findings of fact and conclusions of law, and shall require an appropriate bond to be filed by the receiver and paid for by the licensee. The bond shall be in an amount necessary to protect the licensee in the event of any failure on the part of the receiver to act in a reasonable manner. The bond requirement may be waived by the licensee.

The court may permit the licensee to participate in the continued operation of the facility during the pendency of any receivership ordered pursuant to this section and shall issue an order detailing the nature and scope of participation.

Failure of the licensee to appear at the hearing on the petition shall constitute an admission of all factual allegations contained in the petition for purposes of these proceedings only.

The licensee shall receive notice and a copy of the application each time the receiver applies to the court or the state department for instructions regarding his or her duties under the provisions of this article, when an accounting pursuant to Section 1330 is submitted, and when a report pursuant to Section 1332 or other report is submitted. The licensee shall have an opportunity to present objections or otherwise participate in any such proceeding.

Added Stats 1982 ch 1456 § 2; Amended Stats 1984 ch 1631 § 1.

§ 1328. Liability

(a) Notwithstanding any other provision of law, the receiver shall be liable only for damages resulting from gross negligence in the operation of the facility or intentional tortious acts.

(b) Notwithstanding any other provision of law, the State of California shall be liable only for damages resulting from negligence of the receiver in the operation of the facility.

(c) The licensee shall not be liable for any occurrences during the receivership except to the extent that the occurrences are the result of the licensee's conduct.

Added Stats 1982 ch 1456 § 2.

§ 1329. Powers and duties of receiver; Payment to receiver; Obligation and liability of licensee; Order of court for payment

(a) The receiver appointed pursuant to this article:

(1) May exercise those powers and shall perform those duties ordered by the court, in addition to other duties provided by statute.

(2) Shall operate the facility in such a manner as to assure safety and adequate health care for the residents.

(3) Shall have the same rights to possession of the building in which the facility is located, and of all goods and fixtures in the building at the time the petition for receivership is filed, as the licensee and administrator would have had if the receiver had not been appointed.

(4) May use the funds, building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the facility at the time the petition for receivership was filed.

(5) Shall take title to all revenue coming to the facility in the name of the receiver who shall use it for the following purposes in descending order of priority:

(A) To pay wages to staff. The receiver shall have full power to hire, direct, manage, and discharge employees of the facility, subject to any contractual rights they may have. The receiver shall pay employees at the same rate of compensation, including benefits, that the employees would have received from the licensee.

§ 1329.5. Criteria for dishonor of lease, mortgage, secured transaction or contract

(a) A receiver may not be required to honor any lease, mortgage, secured transaction or other wholly or partially executory contract entered into by

(C) To contract for such outside services as may be needed for the operation of the long-term health care facility. Any contract for outside services in excess of three thousand dollars ($3,000) shall be approved by the court.

(D) To pay commercial creditors of the long-term health care facility. Except as provided in Section 1329.5, the receiver shall honor all leases, mortgages, and secured transactions affecting the building in which the facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of receivership, or which, in the case of a purchase agreement, come due during the period of receivership.

(E) To receive a salary, as approved by the court.

(F) To do all things necessary and proper to maintain and operate the facility in accordance with sound fiscal policies. The receiver shall take such action as is reasonably necessary to protect or conserve the assets or property of which the receiver takes possession and may use such assets or property only in the performance of the powers and duties set out in this section and by order of the court.

(G) To maintain a reasonable return on the licensee's investment.

(b) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver, rather than the licensee, for any goods or services provided by the long-term health care facility after the date of the order. The receiver shall give a receipt for each such payment and shall keep a copy of each receipt on file. The receiver shall deposit amounts received in a special account and shall use this account for all disbursements. Payment to the receiver pursuant to this subdivision shall discharge the obligation to the extent of the payment and shall not thereafter be the basis of a claim by the licensee or any other person. A resident may not be discharged nor may any contract or rights be forfeited or impaired, nor may any forfeiture be effected or liability increased, by reason of an omission to pay the licensee, operator, or other person a sum paid to the receiver pursuant to this subdivision.

(c) Nothing contained in this section shall be construed to suspend, during the temporary management by the receiver, any obligation of the licensee for payment of local, state, or federal taxes. No licensee may be held liable for acts or omissions of the receiver during the term of the temporary management.

(d) Upon petition of the receiver, the court may order immediate payment to the receiver for past services which have been rendered and billed, and the court may also order a sum not to exceed one month's advance payment to the receiver of any sums that will become payable under the Medi-Cal program.

Added Stats 1982 ch 1456 § 2; Amended Stats 1984 ch 1631 § 2.

(B) To preserve patient funds. The receiver shall be entitled to, and shall take, possession of all property or assets of residents which are in the possession of the licensee or operator of the facility. The receiver shall preserve all property, assets, and records of residents of which the receiver takes possession.

the owners or operators of the facility if both of the following criteria are met:

(1) The person seeking payment under the agreement was an operator or controlling person of the facility, as determined by the receiver, or was an affiliate of the operator or controlling person at the time the agreement was made.

(2) The rent, price, or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price, or rate of interest at the time the contract was entered into, as determined by the court.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage, or security interest which the receiver is permitted to avoid pursuant to subdivision (a), and if the real estate or goods are necessary for the continued operation of the facility, the receiver may apply to the court to set a reasonable rent, price, or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on this application within 15 days. The receiver shall send notice of the application to any known owner of the property involved at least 10 days prior to the hearing.

Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or possession of the goods or real estate, subject to the lease or mortgage, which is brought by any person who received the notice required by this subdivision. However, payment by the receiver of the amount determined by the court to be reasonable shall not relieve the owner or operator of the facility from any liability for the difference between the amount paid by the receiver and the amount due under the original lease, mortgage, or security interest.

Added Stats 1984 ch 1631 § 3.

§ 1330. Monthly accounting

A monthly accounting shall be made by the receiver to the state department of all moneys received and expended by the receiver on or before the 15th day of the following month or as ordered by the court, and the remainder of income over expenses for such month shall be returned to the licensee. A copy of the accounting shall be provided to the licensee. The licensee or owner of the long-term health care facility may petition the court for a determination as to the reasonableness of any expenditure made pursuant to paragraph (5) of subdivision (a) of Section 1329.

Added Stats 1982 ch 1456 § 2.

§ 1331. Duration of receiver's management; Termination; Sale, lease, or closure of facility

(a) The receiver shall be appointed for an initial period of not more than six months. The initial six-month period may be extended for additional periods not exceeding six months, as determined by the court pursuant to this section. At the end of four months, the receiver shall report to the court on its assessment of the probability that the long-term health care facility will meet state standards for operation by the end of the initial six-month period and will continue to maintain compliance with those standards after termination of the receiver's management. If it appears that the facility cannot be brought into compliance with state standards within the initial six-month period, the court shall take appropriate action as follows:

(1) Extend the receiver's management for an additional six months if there is a substantial likelihood that the facility will meet state standards within that period and will maintain compliance with the standards after termination of the receiver's management. The receiver shall report to the court in writing upon the facility's progress at the end of six weeks of any extension ordered pursuant to this paragraph.

(2) Order the director to revoke or temporarily suspend, or both, the license pursuant to Section 1296 and extend the receiver's management for the period necessary to transfer patients in accordance with the transfer plan, but in no event for more than six months from the date of the initial appointment of a receiver or 14 days, whichever is greater.

(b) If it appears at the end of six weeks of an extension ordered pursuant to paragraph (1) of subdivision (a) that the facility cannot be brought into compliance with state standards for operation or that it will not maintain compliance with those standards after the receiver's management is terminated, the court shall take appropriate action as specified in paragraph (2) of subdivision (a).

(c) In evaluating the probability that a long-term health care facility will maintain compliance with state standards of operation after the termination of receiver management ordered by the court, the court shall consider at least the following factors:

(1) The duration, frequency, and severity of past violations.

(2) Past and current violations in other long-term health care facilities operated by the licensee.

(3) Efforts by the licensee to prevent and correct past violations.

(4) The financial ability of the licensee to operate in compliance with state standards.

(5) The licensee's willingness and ability to comply with the rehabilitation plan established pursuant to subdivision (d).

(6) The recommendations and reports of the receiver.

(d) Management of a long-term health care facility operated by a receiver pursuant to this article shall not be returned to the licensee or to any agent or employee of the licensee unless a written rehabilitation plan is approved by the court and the plan specifies actions to be taken by the licensee to improve the management of, and the patient care provided by, the facility and to secure and maintain compliance with state standards for operation. The state department shall monitor the facility's conformity with the rehabilitation plan. Failure to follow the plan shall be grounds for license revocation or suspension pursuant to Article 5 (commencing with Section 1294).

(e) The owner of the facility may at any time sell, lease, or close the facility, subject to the following provisions:

(1) If the owner closes the facility, or the sale or lease results in the closure of the facility, the court shall determine if a transfer plan is necessary. If the court so determines, the court shall adopt and implement a transfer plan of not more than 30 days.

(2) If the licensee proposes to sell or lease the facility and the facility will continue to operate as a long-term health care facility, the court and the

state department shall reevaluate any proposed transfer plan. If the court and the state department determine that the sale or lease of the facility will result in compliance with licensing standards, the transfer plan and the receivership shall, subject to such conditions that the court may impose and enforce, be terminated upon the effective date of the sale or lease.

Added Stats 1982 ch 1456 § 2; Amended Stats 1984 ch 1631 § 3.5.

§ 1332. Salary of receiver

The salary of the receiver shall be set by the court commensurate with long-term health care facility industry standards, giving due consideration to the difficulty of the duties undertaken and the qualifications of the appointed receiver, and shall be paid from the revenue coming to the facility. If the revenue is insufficient to pay the salary in addition to other expenses of the operating facility, the receiver's salary shall be paid from the General Fund.

Added Stats 1982 ch 1456 § 2.

§ 1333. State funds

To the extent state funds are advanced for the salary of the receiver or for other expenses in connection with the receivership, as limited by subdivision (d) of Section 1329, the state shall be reimbursed from the revenues accruing to the facility. If the revenues are insufficient to reimburse the state, the unreimbursed amount shall constitute a lien upon the assets of the facility or the proceeds from the sale thereof. The lien shall not attach to the interests of a lessor, unless the lessor is operating the facility.

Added Stats 1982 ch 1456 § 2.

§ 1334. Right to dispose of property interest in facility

(a) Nothing in this article shall impair the right of the owner of a long-term health care facility to dispose of his or her property interests in the facility, but any facility operated by a receiver pursuant to this article shall remain subject to such administration until terminated by the court. The termination shall be promptly effectuated, provided that the interests of the patients have been safeguarded as determined by the court.

(b) Nothing in this article shall limit the power of the court to appoint a receiver under any other applicable provision of law or to order any other remedy available under law.

Added Stats 1982 ch 1456 § 2.

§ 1335. Authority of state department

The state department shall adopt regulations for the administration of this article. Nothing in this article shall impair the authority of the state department to temporarily suspend licenses under Section 1296 or to reach a voluntary agreement with the licensee for alternate management of a long-term health care facility. Nothing in this article shall authorize the state department to interfere in any labor dispute.

Added Stats 1982 ch 1456 § 2.

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special meeting of said board. The sale, conveyance, lease, or other disposition of such property may be made in the manner provided in this section to any person, corporation, county, municipality, or other entity.

Source: L. 57, p. 416, § 1; CRS 53, § 66-4-6; C.R.S. 1963, § 66-4-6.

Am. Jur.2d. See 40 Am. Jur.2d, Hospitals and Asylums, § 3.

25-3-107. Disciplinary actions reported to state board of medical examiners. (1) Any disciplinary action to suspend or revoke the privileges of a licensed physician or podiatrist which is taken by the governing board of a hospital required to be licensed pursuant to this part 1 or required to obtain a certificate of compliance pursuant to section 25-1-107 (1) (l) (II) shall be reported to the Colorado state board of medical examiners, in the form prescribed by said board.

(2) Said hospital shall provide such additional information as is deemed necessary by the Colorado state board of medical examiners to conduct a further investigation and hearing.

Source: L. 76, p. 421, § 7; L. 79, p. 523, § 28.

25-3-108. Receivership. (1) It is the purpose of this section to establish a receivership mechanism which will be available as a remedy for such violations of applicable laws and regulations by a licensee of a long-term health care facility which require facility closure by the department of health in order to safeguard against potential transfer trauma resulting from relocation of its residents as a result of closure of the facility. For the purposes of this section, "long-term health care facility" has the meaning specified in section 25-3-603 (4).

(2) The department of health, the licensee or owner of a long-term health care facility, or the lessee of such facility with the approval of the owner may apply to the district court for the appointment of a receiver to operate the long-term health care facility when:

(a) The department of health has refused to issue a renewal license or has revoked the license of such facility and the action of the department is final; or

(b) The department of health, through the executive director thereof, has taken summary action to suspend the license of any such facility in accordance with the provisions of section 24-4-104 (4), C.R.S. 1973.

(3) The action of the department of health with respect to nonrenewal or revocation of a license and certification for medicaid participation shall not be final for the purposes of paragraph (a) of subsection (2) of this section until all administrative hearings and judicial appeals sought by a licensee of a long-term health care facility have been exhausted or the time permitted for the same has expired and until the decisions resulting from any such appeals, if any, sustain the action of said department.

(4) Application for the appointment of a receiver pursuant to this section shall be to the district court for the county where the long-term health care facility is located. No hearing on such application shall be held sooner than

seventy-two hours after the licensee of such facility has been served with notice thereof, as provided in the Colorado rules of civil procedure; except that when the department exercises its summary powers, an emergency receiver may be appointed upon agreement in writing between the department and licensee, with the approval of the owner, until a hearing for appointment of a receiver as provided in this section. Notice shall also be served upon any owner and any lessee of a long-term health care facility and any holder of a security interest of record in said facility. An application for appointment of a receiver pursuant to this section shall have precedence and priority over any civil or criminal case pending in the district court wherein the application is filed.

(5) For the purposes of this section the action of the department of health exercised pursuant to subsection (2) of this section shall become effective upon appointment of the receiver of the court.

(6) Prior to ordering the appointment of a receiver for the operation of a long-term health care facility, the district court must find:

(a) That grounds for the appointment of a receiver exist as provided in subsection (2) of this section; and

(b) That proper notice as required by subsection (4) of this section has been served; and

(c) That there is a necessity to continue care on a temporary basis at the facility to avoid potential transfer trauma which would serve the best interests of the residents of the facility pending arrangements for the lease, sale, or closure of the facility.

(7) The department of health shall grant the receiver a license pursuant to section 25-3-102 and certification for medicaid participation, and the department of social services shall reimburse the receiver for the long-term health care facility's medicaid residents pursuant to section 26-4-110 (5), C.R.S. 1973.

(8) The appointment of the receiver shall be in accordance with and governed by the provisions of rule 66 of the Colorado rules of civil procedure. The court shall enter an order of appointment and fix the fees and expenses of the receiver. The receiver shall be a licensed nursing home administrator and shall post a bond with adequate sureties as determined by the court, and the receiver may be sued upon the same in the name of the people of the state of Colorado at the instance and for the use of any party injured. The receiver shall perform duties, assume responsibilities, and preserve the long-term health care facility property in accordance with established principles of law for receivers of real property. Such duties and responsibilities shall be determined by the court following a hearing, at which time the parties may appear and be heard. The court shall specify the duties and responsibilities of the receiver in the order of appointment. No security interest in any real or personal property comprising said facility or contained within the facility nor any fixture of the facility shall be impaired or diminished by the receiver, but the receiver shall comply with the standards of the department of health in providing health care to patients.

(9) Nothing in this section shall prevent the court from altering or amending the terms and conditions of the receivership or the receiver's responsibilities and duties following a hearing, at which time the parties may appear and be heard; and nothing in this section shall prohibit the parties from stipulating to the terms and conditions of the receivership and the responsibilities

and duties of the receiver, including the duration thereof, and such stipulation shall be submitted to the court for approval.

(10) A receivership established pursuant to this section may be terminated by the court upon application therefor by the licensee of a long-term health care facility, the department of health, or the receiver. The receivership may be terminated upon a finding by the court that the receivership is no longer necessary, but in no case shall the receivership continue for longer than one hundred eighty days from the date of the initial appointment of the receiver unless extended by written agreement of the parties as provided in subsection (9) of this section.

(11) Upon termination of the receivership, the court shall order a final accounting and finally fix the fees and expenses of the receiver following a hearing, at which time the parties may appear and be heard.

Source: L. 79, p. 1003, § 1.

-108. Receivership.

ed in State ex rel. Colorado Dep't of v. I.D.I., Inc., 642 P.2d 14 (Colo. Ct. App. 1981); In re Estate of Smith v. O'Halloran, 557 F. Supp. 289 (D. Colo. 1983).

Connecticut

Section 19-619 was transferred and set out as § 19a-539 in 1983.

§ 19a-540. Posting of citations. Monthly report by department of health services

(a) Each class A or class B citation shall be prominently posted in the nursing home cited in the manner prescribed by the commissioner of health services so as to be visible to any patient, including those in wheelchairs, and to any employee or visitor of the nursing home until the violation has been corrected to the satisfaction of the commissioner of health services or the citation has been vacated.

(b) The department of health services shall prepare and keep on file a monthly report listing all class A, B and C citations issued, all civil penalties which have been filed as provided in section 19a-526 or paid before such filing and all violations which have been corrected during the previous month. The listing shall include the following: (1) The name and address of the nursing home; (2) the class of the violation and the civil penalty, if any, imposed; and (3) a description of the violation.

(1958 Rev., § 19-620; 1977, P.A. 77-614, § 823, *eff.* Jan. 1, 1979.)

Section 19-620 was transferred and set out as § 19a-540 in 1983.

1977 Amendment

1977, P.A. 77-614, § 823, eff. Jan. 1, 1979, provided for change of terms "commissioner of health" or "state department of health" to "commissioner of health services" or "department of health services", respectively.

§ 19a-541. Receivership of nursing homes: Definitions

The following words and phrases, as used in this section and sections 19a-542 to 19a-549, inclusive, shall have the following meanings, unless the context otherwise requires:

(a) "Nursing home facility" means a facility as defined in section 19a-521;

(b) "Emergency" means a situation, physical condition or one or more practices, methods or operations which presents imminent danger of death or serious physical or mental harm to residents of such facility;

(c) "Transfer trauma" means the medical and psychological reactions to physical transfer that increase the risk of death, or grave illness, or both, in elderly persons;

(d) "Substantial violation" means a violation of law which presents a reasonable likelihood of serious physical or mental harm to residents of such facility;

(e) "Habitual violation" means a violation of law which, due to its repetition, presents a reasonable likelihood of serious physical or mental harm to residents of such facility.

(1958 Rev., § 19-621a; 1978, P.A. 78-227, § 1, eff. Jan. 1, 1979.)

Section 19-621a was transferred and set out as § 19a-541 in 1983.

Effective date:

1978, P.A. 78-227, § 10, provided:

"This act shall take effect January 1, 1979."

§ 19a-542. Application for receivership. Hearing. Emergency order

(a) An application to appoint a receiver for a nursing home facility may be filed in the superior court by the commissioner on aging, the commissioner of health services or the director of the office of protection and advocacy for handicapped and developmentally disabled persons. A resident of a facility or such resident's legally liable relative, conservator or guardian may file a written complaint with the commissioner of health services specifying conditions at the facility which warrant an application to appoint a receiver. If the commissioner of health services fails to resolve such complaint within forty-five days of its receipt or, in the case of a facility which intends to close, within seven days of its receipt, the person who filed the complaint may file an application in the superior court for the appointment of a receiver for such facility. Said court shall immediately notify the attorney general of such application. The court shall hold a hearing not later than ten days after the date the application is filed. Notice of such hearing shall be given to the owner of such facility or such owner's agent for service of process not less than five days prior to such hearing. Such notice shall be posted by the court in a conspicuous place inside such facility for not less than three days prior to such hearing.

(b) Notwithstanding the provisions of subsection (a) of this section the court may appoint a receiver upon an ex parte motion when affidavits, testimony or any other evidence presented indicates that there is a reasonable likelihood an emergency exists in such facility which must be remedied immediately to insure the health, safety and welfare of the patients of such facility. Notice of the application and order shall be served on the owner or his agent for service of process and shall be posted in a conspicuous place inside the facility not later than twenty-four hours after issuance of such order. A hearing on the application shall be held not later than five days after the issuance of such order unless the owner consents to a later date.

(1958 Rev., § 19-621b; 1978, P.A. 78-227, § 2, eff. Jan. 1, 1978; 1980, P.A. 80-309, § 1.)

Section 19-621b was transferred and set out as § 19a-542 in 1983.

1980 Amendment

1980, P.A. 80-309, § 1, amended the first sentence of subsec. (a) by deleting ", as defined in section 19-602 [19a-521]," following "a nursing home facility", by substituting a comma for "or" following "commissioner on aging", and by adding "or the director of the office of protection and advocacy for handicapped and developmentally disabled persons"; and inserted, in subsec. (a), the second through the fourth sentence.

§ 19a-543. Imposition of receivership: Grounds

The court may grant an application for the appointment of a receiver for a nursing home facility upon a finding of any of the following: (1) Such facility is operating without a license issued pursuant to sections 19a-490 to 19a-503, inclusive, or such facility's license has been suspended or revoked pursuant to section 19a-494; (2) such facility intends to close and adequate arrangements for relocation of its residents have not been made at least thirty days prior to closing; (3) there exists in such facility a condition in substantial violation of the public health code, or any other applicable state statutes, or Title XVIII or XIX of the Federal Social Security Act, 42 U.S.C. 301, as amended, or any regulation adopted pursuant to such state or federal laws; (4) there exists in such facility a practice of habitual violation of the standards set by the statutes and regulations designated in subdivision (3) of this section.

(1958 Rev., § 19-621c; 1978, P.A. 78-227, § 3, eff. Jan. 1, 1979.)

Section 19-621c was transferred and set out as § 19a-543 in 1983.

§ 19a–544. Imposition of receivership: Defenses

It shall be a sufficient defense to a receivership application if any owner of a nursing home facility establishes that, (1) he did not have knowledge or could not reasonably have known that any conditions in violation of section 19a–543 existed, or (2) he did not have a reasonable time in which to correct such violations, or (3) the violations listed in the application do not, in fact, exist or, in the event the grounds upon which the petition is based are those set forth in subdivision (2) of section 19a–543, the facility does not intend to close.

(1958 Rev., § 19–621d; 1978, P.A. 78–227, § 4, eff. Jan. 1, 1979; 1980, P.A. 80–309, § 2.)

Section 19–621d was transferred and set out as § 19a–544 in 1983.

1980 Amendment

1980, P.A. 80–309, § 2, added, at the end of the section, "or in the event the grounds upon which the petition is based are those set forth in subdivision (2) of section 19–621c [19a–543], the facility does not intend to close".

§ 19a–545. Duties of receiver

A receiver appointed pursuant to the provisions of sections 19a–541 to 19a–549, inclusive, in operating such facility, shall have the same powers as a receiver of a corporation under section 52–507 and shall exercise such powers to remedy the conditions which constituted grounds for the imposition of receivership, assure adequate health care for the patients and preserve the assets and property of the owner. If a facility is placed in receivership it shall be the duty of the receiver to notify patients and family, except where medically contraindicated. Such receiver may correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety or health of the residents while they remain in the facility, provided the total cost of correction does not exceed three thousand dollars. The court may order expenditures for this purpose in excess of three thousand dollars on application from such receiver. If any resident is transferred or discharged such receiver shall provide for: (1) Transportation of the resident and such resident's belongings and medical records to the place where such resident is being transferred or discharged; (2) aid in locating an alternative placement and discharge planning in accordance with section 19a–535; (3) preparation for transfer to mitigate transfer trauma, including but not limited to, participation by the resident or the resident's guardian in the selection of the resident's alternative placement, explanation of alternative placements and orientation concerning the placement chosen by the resident or the resident's guardian; and (4) custodial care of all property or assets of residents which are in the possession of an owner of the facility. The receiver shall preserve all property, assets and records of residents which the receiver has custody of and shall provide for the prompt transfer of the property, assets and records to the alternative placement of any transferred resident. In no event may the receiver transfer all residents and close a facility without a court order and without preparing a discharge plan for each resident in accordance with section 19a–535.

(1958 Rev., § 19–621e; 1978, P.A. 78–227, § 5, eff. Jan. 1, 1979; 1980, P.A. 80–309, § 3.)

Section 19–621e was transferred and set out as § 19a–545 in 1983.

1980 Amendment

1980, P.A. 80–309, § 3, added the last sentence prohibiting the receiver from transferring residents without court order and without preparing a discharge plan.

§ 19a-546. Authority of receiver concerning leases, mortgages, secured transactions

(a) A receiver may not be required to honor any lease, mortgage, secured transaction or other contract entered into by the owner of the facility if, upon application to the superior court, said court determines that: (1) The person seeking payment under the agreement was an owner or controlling stockholder of the facility or was an affiliate of such owner or controlling stockholder at the time the agreement was made; or (2) the rental, price or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rental, price or rate of interest at the time the contract was entered into.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage or security interest which the receiver is permitted to avoid under subsection (a) and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a reasonable rental, price or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing not later than fifteen days after application is made. Any known owners of the property involved shall receive notice of such application from the receiver at least ten days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or for possession of the goods or real estate subject to the lease, security interest or mortgage involved by any person who received such notice, but the payment does not relieve the owner of the facility of any liability for the difference between the amount paid by the receiver and the amount due under such lease, security interest or mortgage involved.

(c) The provisions of this section shall not apply to a lease, mortgage, secured transaction or other contract entered into with any financial institution regulated by a state or federal agency.

(1958 Rev., § 19-621f; 1978, P.A. 78-227, § 6, eff. Jan. 1, 1979.)

Section 19-621f was transferred and set out as § 19a-546 in 1983.

§ 19a-547. Appointment of receiver. Removal. Bond. Fees

(a) The court may name any responsible individual to act as a receiver, except any state employee or the owner, administrator or any other person with a financial interest in such facility. The court may remove such receiver in accordance with section 52-513. A nursing home receiver appointed pursuant to this section shall be entitled to a reasonable receiver's fee as determined by the court. The receiver shall be liable only in his official capacity for injury to person and property by reason of the conditions of the nursing home. He shall not be personally liable, except for acts or omissions constituting gross, wilful or wanton negligence.

(b) The court, in its discretion, may require a bond of such receiver in accordance with section 52-[illegible].

(c) The court may require the commissioner of health services to provide for the payment of any receiver's fees authorized in subsection (a) upon a showing by such receiver to the satisfaction of the court that (1) the assets of the nursing home facility are not sufficient to make such payment and (2) no other source of payment is available, including the submission of claims in a bankruptcy proceeding.

(1958 Rev., § 19-621g; 1978, P.A. 78-227, § 7, eff. Jan. 1, 1979; 1984, P.A. 84-410, § 1, eff. June 8, 1984.)

Section 19-621g was transferred and set out as § 19a-547 in 1983.

1984 Amendment

1984, P.A. 84-410, § 1, eff. June 8, 1984, inserted subsec. (c).

§ 19a-548. Accounting by receiver

Each receiver shall, during the first week in January, April, July and October in each year, sign, swear to and file with the clerk of the court by which he was appointed a full and detailed account of his doings as such receiver for the three months next preceding, together with a statement of all court orders passed during such three months and the present condition and prospects of the facility in his charge, and cause a motion for a hearing and approval of the same to be placed on the short calendar.

(1958 Rev., § 19-621h; 1978, P.A. 78-227, § 8, eff. Jan. 1, 1979.)

Section 19-621h was transferred and set out as § 19a-548 in 1983.

§ 19a-549. Termination of receivership

The superior court, upon a motion by the receiver or the owner of such facility, may terminate the receivership if it finds that such facility has been rehabilitated so that the violations complained of no longer exist or if such receivership was instituted pursuant to subdivision (2) of section 19a-543, the orderly transfer of the patients has been completed and such facility is ready to be closed. Upon such finding, the court may terminate the receivership and return such facility to its owner. In its termination order the court may include such terms as it deems necessary to prevent the conditions complained of from recurring.

(1958 Rev., § 19-621i; 1978, P.A. 78-227, § 9, eff. Jan. 1, 1979; 1980, P.A. 80-309, § 4.)

Section 19-621i was transferred and set out as § 19a-549 in 1983.

1980 Amendment

1980, P.A. 80-309, § 4, substituted, in the second sentence, "may" for "shall" following "the court"; and added the last sentence providing for inclusion of terms to prevent conditions complained of from recurring.

§ 19a-550. Patients' bill of rights

(a) There is established a patients' bill of rights for any person admitted as a patient to any nursing home facility. Said patients' bill of rights shall provide that each such patient: (1) Is fully informed, as evidenced by his written acknowledgment, prior to or at the time of admission and during his stay, of these rights and of all rules and regulations governing patient conduct and responsibilities; (2) is fully informed, prior to or at the time of admission and during his stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by basic per diem rate; (3) is fully informed, by a physician, of his medical condition unless medically contraindicated, as documented by the physician in his medical record, and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; (4) is transferred or discharged only for medical reasons, or for his welfare or that of other patients, as documented in his medical record; or, in the case of a private patient, for his nonpayment or arrearage of more than fifteen days of the per diem room rates established by the nursing home pursuant to approval by the commission on hospitals and health care for his stay, except as prohibited by the Social Security Act, and in the case of

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the provisions of s. 400.23. Fines paid by any nursing home facility licensee under the provisions of this subsection shall be deposited in the Resident Protection Trust Fund and expended as provided in s. 400.063.

(3) The department may issue an order immediately suspending or revoking a license when it determines that any condition in the facility presents a danger to the health, safety, or welfare of the residents in the facility.

(4) The department may impose an immediate moratorium on admissions to any facility when the department determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility.

Amended by Laws 1977, c. 77-147, § 239, eff. Aug. 2, 1977; Laws 1978, c. 78-95, § 19, eff. May 26, 1978; Laws 1979, c. 79-268, § 6, eff. Oct. 1, 1979; Laws 1980, c. 80-186, § 7, eff. Oct. 1, 1980; Laws 1983, c. 83-181, § 15, eff. Oct. 1, 1983.

Repeal

For repeal of this section, see the italicized note at the head of this chapter.

Laws 1977, c. 77-147, a reviser's bill, amended this section to reflect reorganization of the department of health and rehabilitative services by Laws 1975, c. 75-48.

Laws 1978, c. 78-95, deleted provisions of this section containing procedural language superseded or made redundant by chapter 120, the Administrative Procedure Act.

Laws 1979, c. 79-268, § 6, designated subsec. (1) and inserted in the first sentence thereof ", not to exceed $500 per violation per day" and the subdivision statutory references, and added subsecs. (2) to (4).

Laws 1980, c. 80-186, § 7, changed the statute reference in the first sentence of subsec. (1) and added the last sentence to subsec. (2).

Laws 1983, c. 83-181, § 15, substituted references to "part" for "chapter" and "resident" for "patient".

Notes of Decisions

1. Construction and application

On complaint by department of health and rehabilitative services that nursing home had been operated without licensed administrator, in which findings were fully supported by record and penalty of $5,000 was within permissible range of § 400.121, District Court of Appeal was without authority to interfere with penalty imposed by department. Magnolias Nursing and Convalescent Center v. Department of Health and Rehabilitative Services, Office of Licensure and Certification, App.1 Dist., 438 So.2d 421 (1983) review denied 449 So.2d 265.

400.125. Injunction proceedings authorized

(1) The Department of Health and Rehabilitative Services may institute injunction proceedings in a court of competent jurisdiction to:

(a) Enforce the provisions of this part or any minimum standard, rule, regulation, or order issued or entered into pursuant thereto; or

Amended by Laws 1983, c. 83-181, § 16, eff. Oct. 1, 1983.

[See main volume for text of (1)(b) and (2)]

Repeal

For repeal of this section, see the italicized note at the head of this chapter.

Laws 1983, c. 83-181, § 16, substituted "part" for "chapter" in subsec. (1)(a).

400.126. Receivership proceedings

(1) As an alternative to or in conjunction with an injunctive proceeding, the department may petition a court of competent jurisdiction for the appointment of a receiver, when any of the following conditions exist:

(a) Any person is operating a facility without a license and refuses to make application for a license as required by s. 400.062.

(b) The licensee is closing the facility or has informed the department that it intends to close the facility and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility. However, the failure on the part of the department, after receiving notice of the closing of a facility that is certified to provide services under Title XIX of the Social Security Act,[1] a minimum of 90 days prior to the closing date, to make adequate arrangement for relocating those residents who are receiving assistance under s. 409.266 shall in and of itself not be grounds to petition for the appointment of a receiver. Under these circumstances, if a facility remains open beyond the closing date, the department shall reimburse the facility for all costs incurred, up to the cap, for those residents who are receiving assistance under s. 409.266, provided the facility continues to be licensed pursuant to this part and certified to provide services under Title XIX of the Social Security Act.[1]

(c) The department determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or a substantial probability that death or serious physical harm would result therefrom.

(d) The licensee cannot meet its financial obligation for providing food, shelter, care, and utilities. Evidence such as the issuance of bad checks or an accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities shall constitute prima facie evidence that the ownership of the facility lacks the financial ability to operate the home in accordance with the requirements of this part and all rules promulgated hereunder.

(2) Petitions for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within 5 days of the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition. The department shall notify the owner or administrator of the facility named in the petition of the filing of the petition and the date set for the hearing. The court may grant the petition only upon finding that the health, safety, or welfare of residents of the facility would be threatened if a condition existing at the time the petition was filed is permitted to continue. A receiver may not be appointed ex parte unless the court determines that one or more of the conditions in subsection (1) exist; that the facility owner or administrator cannot be found; that all reasonable means of locating the owner or the administrator and notifying him of the petition and hearing have been exhausted; or that the owner or administrator, after notification of the hearing, chooses not to attend. After such findings, the court may appoint any person qualified by education, training, or experience to carry out the responsibilities of a receiver pursuant to this section, who must either be qualified pursuant to s. 400.20 or who must employ a licensed nursing home administrator in compliance with s. 400.20, except that the court may not appoint any owner or affiliate of the facility which is in receivership. The receiver may be selected from a list of persons qualified to act as receivers developed by the department and presented to the court with each petition for receivership. Under no circumstances shall the department or designated departmental employee be appointed as a receiver for more than 60 days; however, the receiver may petition the court, one time only, for a 30-day extension. The court shall grant the extension upon a showing of good cause.

(3) The receiver shall make provisions for the continued health, safety, and welfare of all residents of the facility and:

(a) Shall exercise those powers and perform those duties set out by the court.

(b) Shall operate the facility in such a manner as to assure safety and adequate health care for the residents.

(c) Shall take such action as is reasonably necessary to protect or conserve the assets or property of the facility for which the receiver is appointed, or the proceeds from any transfer thereof, and may use them only in the performance of the powers and duties set forth in this section and by order of the court.

(d) May use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the facility at the time the petition for receivership was filed. The receiver shall collect payments for all goods and services provided to residents or others during the period of the receivership at the same rate of payment charged by the owners at the time the petition for receivership was filed, or at a fair and reasonable rate otherwise approved by the court for private-pay residents. The receiver may apply to the department for a rate increase for Title XIX of the Social Security Act [1] residents if the facility is not receiving the "state reimbursement cap" and expenditures justify an increase in the rate.

(e) May correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety or health of residents while they remain in the facility, provided the total cost of correction does not exceed $3,000. The court may order expenditures for this purpose in excess of $3,000 on application from the receiver after notice to the owner and a hearing.

(f) May let contracts and hire agents and employees to carry out the powers and duties of the receiver under this section.

(g) Shall honor all leases, mortgages, and secured transactions governing the building in which the facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of receivership, or which, in the case of a purchase agreement, become due during the period of receivership.

(h) Shall have full power to direct and manage and to discharge employees of the facility, subject to any contract rights they may have. The receiver shall pay employees at the rate of compensation, including benefits, approved by the court. A receivership does not relieve the owner of any obligation to employees made prior to the appointment of a receiver and not carried out by the receiver.

(i) Shall be entitled to take possession of all property or assets of residents which are in the possession of a facility or its owner. The receiver shall preserve all property or assets and all resident records of which the receiver takes possession and shall provide for the prompt transfer of the property, assets, and records to the new placement of any transferred resident. An inventory list certified by the owner and receiver shall be made at the time the receiver takes possession of the facility.

(4)(a) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver for any goods or services provided by the receiver after the date of the order if the person would have been liable for the goods or services as supplied by the owner. The receiver shall give a receipt for each payment and shall keep a copy of each receipt on file. The receiver shall deposit accounts received in a separate account and shall use this account for all disbursements.

(b) The receiver may bring an action to enforce the liability created by paragraph (a).

(c) A payment to the receiver of any sum owing to the facility or its owner shall discharge any obligation to the facility to the extent of the payment.

(5)(a) A receiver may petition the court that he not be required to honor any lease, mortgage, secured transaction, or other wholly or partially executory contract entered into by the owner of the facility if the rent, price, or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price, or rate of interest at the time the contract was entered into, or if any material provision of the agreement was unreasonable, when compared to contracts negotiated under similar conditions. Any relief in this form provided by the court shall be limited to the life of the receivership, unless otherwise determined by the court.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage, or security interest which the receiver has obtained a court order to avoid under paragraph (a), and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a [illegible] rental, price, or rate of interest to be paid by the receiver during the duration [illegible] receivership. The court shall hold a hearing on the application within 15 days. [illegible] receiver shall send notice of the application to any known persons who own the [illegible] involved or mortgage holders at least 10 days prior to the hearing. Payment by [illegible] receiver of the amount determined by the court to be reasonable is a defense to any [illegible] against the receiver for payment or for possession of the goods or real estate [illegible] the lease, security interest, or mortgage involved by any person who received such [illegible], but the payment does not relieve the owner of the facility of any liability [illegible] difference between the amount paid by the receiver and the amount due under [illegible] original lease, security interest, or mortgage involved.

(6) The court shall set the compensation of the receiver, which will be [illegible] necessary expense of a receivership.

(7) A receiver may be held liable in a personal capacity only for the receiver's [illegible] gross negligence, intentional acts, or breach of fiduciary duty.

(8) The court may require a receiver to post a bond.

(9) The court may terminate a receivership when:

(a) The court determines that the receivership is no longer necessary because the conditions which gave rise to the receivership no longer exist; or

(b) All of the residents in the facility have been transferred or discharged.

(10) Within 30 days after the termination, unless this time period is extended by the court, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected and disbursed, and of the expenses of the receivership.

(11) Nothing in this section shall be deemed to relieve any owner, administrator, [illegible] employee of a facility placed in receivership of any civil or criminal liability incurred, or [illegible] any duty imposed by law, by reason of acts or omissions of the owner, administrator, [illegible] employee prior to the appointment of a receiver; nor shall anything contained in this section be construed to suspend during the receivership any obligation of the owner, administrator, or employee for payment of taxes or other operating and maintenance expenses of the facility, or of the owner, administrator, employee, or any other person for the payment of mortgages or liens. The owner shall retain the right to sell or mortgage any facility under receivership, subject to approval of the court which ordered the receivership. A licensee that is placed in receivership by the court is liable for all expenses and costs incurred by the Resident Protection Trust Fund which occur as a result of the receivership.

Laws 1980, c. 80-186, §§ 8, 18, eff. Oct. 1, 1980. Amended by Laws 1983, c. 83-181, § 17, eff. Oct. 1, 1983; Laws 1983, c. 83-218, § 51, eff. Aug. 12, 1983.

[1] 42 U.S.C.A. § 1396 et seq.

Repeal

For repeal of this section, see the italicized note at the head of this chapter.

Laws 1983, c. 83-181, § 17, substituted reference to "resident" for "patient", rewrote subsecs. (1) and (10) and the sixth sentence of subsec. (2), and added the third sentence of subsec. (11).

Laws 1983, c. 83-218, was a reviser's correction bill which deleted subsec. (12). See Reviser's Note—1983.

Reviser's Note—1983:

[Subsection (12) was] * * * superseded by ss. 2 and 3, ch. 81-318, Laws of Florida, which replaced the Regulatory Reform Act of 1976 with the Regulatory Sunset Act.

400.141. Administration and management of nursing home facilities

Every licensed facility shall comply with all applicable standards, rules, and regulations of the Department of Health and Rehabilitative Services and shall:

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Department, to any resident who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The facility shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives. Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility as provided under Section 3-419.[1]
P.A. 81-223, § 3-423, eff. March 1, 1980.

[1] Paragraph 4153-419 of this chapter.

Library References

Asylums ⇐3.
C.J.S. Asylums § 5.

Part 5. Monitors and Receivership

4153-501. Conditions justifying monitors or receivers

§ 3-501. The Department may place an employee or agent to serve as a monitor in a facility or may petition the circuit court for appointment of a receiver for a facility, or both, when any of the following conditions exist:

(a) The facility is operating without a license;

(b) The Department has suspended, revoked or refused to renew the existing license of the facility;

(c) The facility is closing or has informed the Department that it intends to close and adequate arrangements for relocation of residents have not been made at least 30 days prior to closure; or

(d) The Department determines that an emergency exists, whether or not it has initiated revocation or nonrenewal procedures, if because of the unwillingness or inability of the licensee to remedy the emergency the Department believes a monitor or receiver is necessary.

P.A. 81-223, § 3-501, eff. March 1, 1980.

Library References

Asylums ⇐3.
Receivers ⇐11.
C.J.S. Asylums § 5.
C.J.S. Receivers §§ 13, 14.

4153-502. Monitors—Reports

§ 3-502. In any situation described in Section 3-501,[1] the Department may place a qualified person to act as monitor in the facility. The monitor shall observe operation of the facility, assist the facility by advising it on how to comply with the State regulations, and shall report periodically to the Department on the operation of the facility.

P.A. 81-223, § 3-502, eff. March 1, 1980.

[1] Paragraph 4153-501 of this chapter.

4153-503. Petition for receivership

§ 3-503. Where a resident, a resident's representative or a resident's next of kin believes that an emergency exists each of them, collectively or separately, may file a verified petition to the circuit court for the county in which the facility is located for an order placing the facility under the control of a receiver.

P.A. 81-223, § 3-503, eff. March 1, 1980.

Library References

Receivers ⇐9.
C.J.S. Receivers § 11.

notice shall be filed with the recorder. If the lien is on personal property, the lien shall be filed with the Secretary of State. The notice shall specify the name of the person against whom the lien is claimed, the name of the receiver, the dates of the petition for receivership and the termination of receivership, a description of the property involved and the amount claimed. No lien shall exist under this Article against any person, on any property, or for any amount not specified in the notice filed under this subsection (e).

P.A. 81-223, § 3-516, eff. March 1, 1980. Amended by P.A. 83-358, § 90, eff. Sept. 14, 1983.

[1] Paragraphs 4153-506 and 4153-508 of this chapter.

[2] Paragraph 4153-511 of this chapter.

P.A. 83-358 revised references to Recorders of Deeds.

C.J.S. Receivers § 189.

Library References

Receivers ⇔90.

4153-517. Civil and criminal liability during receivership—Right to sell or mortgage facility

§ 3-517. Nothing in this Act shall be deemed to relieve any owner, administrator or employee of a facility placed in receivership of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner, administrator, or employee prior to the appointment of a receiver; nor shall anything contained in this Act be construed to suspend during the receivership any obligation of the owner, administrator, or employee for payment of taxes or other operating and maintenance expenses of the facility nor of the owner, administrator, employee or any other person for the payment of mortgages or liens. The owner shall retain the right to sell or mortgage any facility under receivership, subject to approval of the court which ordered the receivership.

P.A. 81-223, § 3-517, eff. March 1, 1980.

Library References

Asylums ⇔7.
C.J.S. Asylums § 9.

Part 6. Duties

4153-601. Liability to residents

§ 3-601. The owner and licensee are liable to a resident for any intentional or negligent act or omission of their agents or employees which injures the resident.

P.A. 81-223, § 3-601, eff. March 1, 1980.

Library References

Asylums ⇔7.
C.J.S. Asylums § 9.

4153-602. Triple damages—Costs and attorney fees

§ 3-602. The licensee shall pay 3 times the actual damages, or $500, whichever is greater, and costs and attorney's fees to a facility resident whose rights, as specified in Part 1 of Article II of this Act,[1] are violated.

P.A. 81-223, § 3-602, eff. March 1, 1980.

[1] Paragraph 4152-101 of this chapter.

Law Review Commentaries

Statutory attorneys' fees. Andrea Saltzman, 1985, 73 Ill.Bar J. 266.

Library References

Asylums ⇔8.
C.J.S. Asylums § 10.

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operate the facility on a sound financial basis and in compliance with this chapter and the rules or minimum standards promulgated under this chapter, and asking that the court approve surrender of the facility's license to the department and subsequent return of control of the facility's premises to the owners of the premises.

4. Payment of the expenses of a receivership established under this section is the responsibility of the facility for which the receiver is appointed, unless the court directs otherwise. The expenses include, but are not limited to:

a. Salary of the receiver.

b. Expenses incurred by the facility for the continuing care of the residents of the facility.

c. Expenses incurred by the facility for the maintenance of buildings and grounds of the facility.

d. Expenses incurred by the facility in the ordinary course of business, such as employees' salaries and accounts receivable.

The receiver is not personally liable for the expenses of the facility during the receivership. The receiver is an employee of the state as defined in section 25A.2, subsection 3, only for the purpose of defending a claim filed against the receiver. Chapter 25A applies to all suits filed against the receiver.

5. This section does not:

a. Preclude the sale or lease of a health care facility, and the transfer or assignment of the facility's license in the manner prescribed by section 135C.8, while the facility is in receivership, provided these actions are not taken without approval of the receiver.

b. Affect the civil or criminal liability of the licensee of the facility placed in receivership, for any acts or omissions of the licensee which occurred before the receiver was appointed.

Added by Acts 1980 (68 G.A.) ch. 1044, § 6. Amended by Acts 1984 (70 G.A.) ch. 1136, § 1.

1984 Amendment: Revised subsec. 4 by adding the second sentence thereof, adding pars. a to d, and by adding the final paragraph thereof, relating to personal liability of receiver.

Library References

Asylums and Institutional Care Facilities ⇐3.

Hospitals ⇐3.

C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

C.J.S. Hospitals § 5.

135C.31. Discharge of medicaid patients

A resident of a health care facility shall not be discharged solely because the cost of the resident's care is being paid under chapter 249A or because the resident's source of payment is changing from private support to payment under chapter 249A.

Added by Acts 1981 (69 G.A.) ch. 60, § 2.

Title of Act:

An Act relating to the rights of residents of health care facilities and providing penalties. Acts 1981 (69 G.A.) ch. 60.

135C.32 to 135C.35. Reserved

VIOLATIONS

135C.36. Violations classified

Every violation by a health care facility of any provision of this chapter or of the rules adopted pursuant to it shall be classified by the department in accordance with this

Iowa Code Ann. Supp. § 135-C-30

135C.29. License list to county commissioner of elections

To facilitate the implementation of section 53.8, subsection 3 and section 53.22, the commissioner shall provide to each county commissioner of elections at least annually a list of each licensed health care facility in that county. The list shall include the street address or location, and the mailing address if it is other than the street address or location, of each facility.

Added by Acts 1975 (66 G.A.) ch. 81, § 124.

Library References
Elections ⟹106.
C.J.S. Elections §§ 39, 46.

135C.30. Operation of facility under receivership

When so authorized by section 135C.11, subsection 2, or section 135C.12, subsection 1, the commissioner may file a verified application in the district court of the county where a health care facility licensed under this chapter is located, requesting that an individual nominated by the commissioner be appointed as receiver for the facility with responsibility to bring the operation and condition of the facility into conformity with this chapter and the rules or minimum standards promulgated under this chapter.

1. The court shall expeditiously hold a hearing on the application, at which the commissioner shall present evidence in support of the application. The licensee against whose facility the petition is filed may also present evidence, and both parties may subpoena witnesses. The court may appoint a receiver for the health care facility in advance of the hearing if the commissioner's verified application states that an emergency exists which presents an imminent danger of resultant death or physical harm to the residents of the facility. If the licensee against whose facility the receivership petition is filed informs the court at or before the time set for the hearing that the licensee does not object to the application, the court shall waive the hearing and at once appoint a receiver for the facility.

2. The court, on the basis of the verified application and evidence presented at the hearing, may order the facility placed under receivership, and if so ordered, the court shall direct either that the receiver assume the duties of administrator of the health care facility or that the receiver supervise the facility's administrator in conducting the day-to-day business of the facility. The receiver shall be empowered to control the facility's financial resources and to apply its revenues as the receiver deems necessary to the operation of the facility in compliance with this chapter and the rules or minimum standards promulgated under this chapter, but shall be accountable to the court for management of the facility's financial resources.

3. A receivership established under this section may be terminated by the district court which established it, after a hearing upon an application for termination. The application may be filed:

a. Jointly by the receiver and the current licensee of the health care facility which is in receivership, stating that the deficiencies in the operation, maintenance or other circumstances which were the grounds for establishment of the receivership have been corrected and that there are reasonable grounds to believe that the facility will be operated in compliance with this chapter and the rules or minimum standards promulgated under this chapter.

b. By the current licensee of the facility, alleging that termination of the receivership is merited for the reasons set forth in paragraph "a" of this subsection, but that the receiver has declined to join in the petition for termination of the receivership.

c. By the receiver, stating that all residents of the facility have been relocated elsewhere and that there are reasonable grounds to believe it will not be feasible to again

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39-947.

Revisor's Note:

This section was amended by L. 1984, ch. 313, § 67, effective July 1, 1985.

39-948.

Revisor's Note:

This section was amended by L. 1984, ch. 313, § 68, effective July 1, 1985.

39-960. Expenditures from moneys appropriated for purposes of act; when authorized; repayment. The secretary of social and rehabilitation services, upon request of a receiver, may authorize expenditures from moneys appropriated for purposes set forth in this act if incoming payments from the operation of the adult care home are less than the cost incurred by the receiver in the performance of the receiver's functions as receiver or for purposes of initial operating expenses of the receivership. Any payments made by the secretary of social and rehabilitation services pursuant to this section shall be owed by the owner or licensee and repaid to the secretary of social and rehabilitation services when the receivership is terminated pursuant to K.S.A. 39-963 and amendments thereto and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.

History: L. 1978, ch. 162, § 7; L. 1984, ch. 158, § 1; July 1.

39-961. Department of health and environment to assist receiver; expenses of department; repayment. The personnel and facilities of the department of health and environment shall be available to the receiver for the purposes of carrying out the receiver's duties as receiver as authorized by the secretary of health and environment.

The department of health and environment shall itemize and keep a ledger showing costs of personnel and other expenses establishing the receivership and assisting the receiver and such amount shall be owed by the owner or licensee to the department of health and environment. Such department shall submit a bill for such expenses to the receiver for inclusion in the receiver's final accounting. Any amount so billed and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.

History: L. 1978, ch. 162, § 8; L. 1984, ch. 158, § 2; July 1.

39-963. Termination of receivership; circumstances; accounting and disposition of money; court orders for recovery of certain expenses and costs. (a) The court shall terminate the receivership only under any of the following circumstances:

(1) Twenty-four months after the date on which the receivership was ordered;

(2) a new license, other than the license granted to the receiver under K.S.A. 39-958 and amendments thereto, has been granted to operate the adult care home; or

(3) at such time as all of the residents in the adult care home have been provided alternative modes of health care, either in another adult care home or otherwise.

(b) At the time of termination of the receivership, the receiver shall render a full and complete accounting to the district court and shall make disposition of surplus money at the direction of the district court.

The court may make such additional orders as are appropriate to recover the expenses and costs to the department of health and environment and the secretary of social and rehabilitation services incurred pursuant to K.S.A. 39-960 or 39-961 and amendments thereto.

History: L. 1978, ch. 162, § 10; L. 1984, ch. 158, § 3; July 1.

Article 10.—DAY CARE PROGRAMS FOR MENTALLY RETARDED AND HANDICAPPED CHILDREN

39-1003. Secretary not to exercise authority until funds available and standards satisfied; assumption of obligations by local authorities. The secretary shall make no commitment or enter into any agreement pursuant to exercising authority under this act until the secretary determines that sufficient funds are available to meet the state's share of the costs. The secretary shall not enter into any such agreement until the secretary determines that standards approved by the secretary have been satisfied. The secretary shall also receive assurance that the local organizations applying for aid have sufficient funds available to meet any obligations assumed under the agreement.

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environment or the hearing officer shall have the authority to subpoena witnesses, administer oaths and take testimony. Within fifteen (15) days after the hearing, the secretary of health and environment shall affirm, modify or reverse the assessment of the civil penalty and shall give written notice of such decision to the licensee. Such notice shall be served upon the licensee either personally or by certified mail, return receipt requested. If the secretary sustains the appeal, any civil penalties collected shall be refunded forthwith to the appellant licensee with interest at the rate established by K.S.A. 16-204 from the date of payment of the civil penalties to the secretary. If the secretary denies the appeal and no appeal from the secretary is taken to the district court within thirty (30) days following the secretary's decision, the secretary shall dispose of any civil penalties collected as provided in K.S.A. 39-949.

History: L. 1978, ch. 161, § 3; L. 1980, ch. 127, § 3; July 1.

39-948. Appeals to district court; disposition of civil penalties. (a) A licensee may appeal to the district court from a decision of the secretary under K.S.A. 39-947. The appeal shall be tried *de novo.*

(b) An appeal to the district court or to an appellate court shall not stay the payment of the civil penalty. If the court sustains the appeal, the secretary of health and environment shall refund forthwith the payment of any civil penalties to the licensee with interest at the rate established by K.S.A. 1980 Supp. 16-204 from the date of payment of the civil penalties to the secretary. If the court denies the appeal, the secretary of health and environment shall dispose of any civil penalties collected as provided in K.S.A. 39-949.

History: L. 1978, ch. 161, § 4; L. 1980, ch. 127, § 4; July 1.

39-949. Disposition of moneys. All civil penalties collected pursuant to the provisions of this act shall be deposited in the state general fund.

History: L. 1978, ch. 161, § 5; July 1.

39-950. Rules and regulations. The secretary of health and environment may adopt rules and regulations necessary to carry out the provisions of this act.

History: L. 1978, ch. 161, § 6; July 1.

39-951. Authority granted under act additional and not limiting. The authority granted to the secretary of health and environment under this act is in addition to other statutory authority the secretary has to require the licensing and operation of adult care homes and is not to be construed to limit any of the powers and duties of the secretary under article 9 of chapter 39 of the Kansas Statutes Annotated.

History: L. 1978, ch. 161, § 7; July 1.

39-952. Correction order not issued, when. The secretary of health and environment or the secretary's designee shall not issue a correction order to a person licensed to operate an adult care home because of a violation of a provision of article 9 of chapter 39 of the Kansas Statutes Annotated or a rule and regulation adopted thereunder which was caused by any person licensed by the state board of healing arts if such person licensed by the state board of healing arts is not an owner, operator or employee of the adult care home and if the person licensed to operate the adult care home shows that he or she has exercised reasonable diligence in notifying such person licensed by the state board of healing arts of his or her duty to the residents of the adult care home.

History: L. 1978, ch. 161, § 8; July 1.

39-953. Citation of act. K.S.A. 39-923 to 39-944, inclusive, and acts amendatory thereof or supplemental thereto, and K.S.A. 39-931a and 39-945 to 39-952, inclusive, and acts amendatory thereof or supplemental thereto, shall be known and may be cited as the adult care home licensure act.

History: L. 1978, ch. 161, § 10; July 1.

RECEIVERSHIP

39-954. Application for receiver; order appointing; when appointed. The secretary of health and environment, the owner of an adult care home, or the person licensed to operate an adult care home may file an application with the district court for an order appointing the secretary of health and environment or the designee of the secretary as receiver to operate an adult care home whenever: (a) Conditions exist in the adult care home that are life threatening or endangering to the residents of the adult care home; (b) the adult care home is insolvent;

or (c) the secretary of health and environment has issued an order revoking the license of the adult care home.

History: L. 1978, ch. 162, § 1; July 1.

39-955. Filing application for receivership; contents. The application for receivership shall be filed in the district court in the county where the adult care home is located. The application shall be verified and set forth the specific reasons therefor.

History: L. 1978, ch. 162, § 2; July 1.

39-956. Service of copies of application for receivership; posting in adult care home. The applicant shall serve those persons set forth in K.S.A. 39-954 with copies of the application. Service of process shall be as provided for under the code of civil procedure. The applicant shall also send five (5) copies of the application for receivership to the adult care home. The adult care home shall post the copies of the application in conspicuous places within the adult care home.

History: L. 1978, ch. 162, § 3; July 1.

39-957. Answer to application for receivership. A party shall file an answer to the application within five (5) days after the service of the application upon such person.

History: L. 1978, ch. 162, § 4; July 1.

39-958. Priority of application for receivership in district court; evidence; appointment of receiver; certain statutes inapplicable to license granted receiver; length of license. The application for receivership shall be given priority by the district court and shall be heard no later than the seventh (7th) day following the filing of the application. A continuance of no more than ten (10) days may be granted by the district court for good cause. The district court shall give all parties who have filed an answer the opportunity to present evidence pertaining to the application. If the district court finds that the facts warrant the granting of the application, the court shall appoint the secretary of health and environment or the designee of the secretary as receiver to operate the home.

Upon the appointment of a receiver under this section, the receiver shall be granted a license by the licensing agency to operate an adult care home as provided under the provisions of article 9 of chapter 39 of the Kansas Statutes Annotated, and acts amending the provisions thereof or acts supplemental thereto. The provisions of article 9 of chapter 39 of the Kansas Statutes Annotated, and acts amending the provisions thereof and acts supplemental thereto, relating to inspection prior to granting a license to operate an adult care home and relating to payment of license fees shall not apply to a license granted to a receiver under this section, and such license shall remain in effect during the existence of the receivership and shall expire on the termination of the receivership. The receiver shall make application for the license on forms provided for this purpose by the licensing agency.

History: L. 1978, ch. 162, § 5; July 1.

39-959. Powers and duties of receiver. A receiver appointed in accordance with the provisions of this act shall have the following powers and duties:

(a) Conduct the day to day business operations of the adult care home;

(b) reimburse the owner or licensee, as appropriate, a fair monthly rental for the adult care home, taking into account all relevant factors, including the condition of such adult care home and set-offs arising from improvements made by the receiver;

(c) give fair compensation to the owner or licensee, as appropriate, for all property taken or used during the course of the receivership if such person has not previously received compensation for the property being taken or used;

(d) correct or eliminate any deficiency in the adult care home that concerns the health, safety, nutrition, or sanitation of the residents of the adult care home and is life threatening or endangering;

(e) enter into contracts as necessary to carry out his or her duties as receiver and incur expenses for individual items of repairs, improvements or supplies without the procurement of competitive bids, if otherwise required by law, where the total amount of such individual item does not exceed five hundred dollars ($500);

(f) collect incoming payments from all sources and apply them to the costs incurred in the performance of his or her functions as receiver including the compensation of the receiver, if any;

(g) honor all existing leases, mortgages, chattel mortgages and security interests;

(h) operate the adult care home so as to provide safe and adequate health care for the residents of the adult care home;

(i) provide for the orderly transfer of all residents in the adult care home to other adult care homes or make other provisions for their continued safety and health care, as necessary;

(j) other powers and duties as authorized or imposed by the district court.

History: L. 1978, ch. 162, § 6; July 1.

39-960. Expenditures from moneys appropriated for purposes of act; when authorized. The secretary of social and rehabilitation services, upon request of a receiver, may authorize expenditures from moneys appropriated for purposes set forth in this act if incoming payments from the operation of the adult care home are less than the cost incurred by the receiver in the performance of his or her functions as receiver or for purposes of initial operating expenses of the receivership.

History: L. 1978, ch. 162, § 7; July 1.

39-961. Personnel and facilities of department of health and environment available to assist receiver. The personnel and facilities of the department of health and environment shall be available to the receiver for the purposes of carrying out his or her duties as receiver as authorized by the secretary of health and environment.

History: L. 1978, ch. 162, § 8; July 1.

39-962. Supervision of district court; final accounting; removal. The receiver shall be subject to the supervision of the district court. The receiver shall file a final accounting with the district court upon the termination of the receivership. The receiver shall be subject to removal by the district court for good cause.

History: L. 1978, ch. 162, § 9; July 1.

39-963. Termination of receivership; circumstances; accounting and disposition of money. (a) The court shall terminate the receivership only under any of the following circumstances:

(1) Twenty-four (24) months after the date on which the receivership was ordered;

(2) a new license, other than the license granted to the receiver under K.S.A. 39-958, has been granted to operate the adult care home; or

(3) at such time as all of the residents in the adult care home have been provided alternative modes of health care, either in another adult care home or otherwise.

(b) At the time of termination of the receivership, the receiver shall render a full and complete accounting to the district court and shall make disposition of surplus money at the direction of the district court.

History: L. 1978, ch. 162, § 10; July 1.

Article 10.—DAY CARE PROGRAMS FOR MENTALLY RETARDED AND HANDICAPPED CHILDREN

39-1001. Purpose of act. The purpose of this act shall be to aid in development, maintenance, improvement or expansion of day care programs for the mentally retarded and other handicapped children in this state.

History: L. 1965, ch. 291, § 1; June 30.

39-1002. Secretary of social and rehabilitation services designated as official to accept and disburse funds. The secretary of social and rehabilitation services hereinafter referred to as the secretary is hereby designated as the official of this state authorized to accept and disburse funds made available to the secretary for grants-in-aid to eligible local community organizations for day care programs for mentally retarded or other handicapped children. The secretary is authorized to accept any moneys made available to the state by the federal government or any agency thereof and to accept and account for state appropriations, gifts and donations from any other sources.

History: L. 1965, ch. 291, § 2; June 30.

39-1003. Same; secretary not to exercise authority until funds available; standards; assumption of obligations by local authorities. The secretary shall make no commitment or enter into any agreement pursuant to exercising authority under this act until he has determined that sufficient funds are available for meeting the state's share of the costs; and shall not enter into any such agreement until standards recommended by the council created by K.S.A. 39-1004 and approved by the secretary have been complied with. The secretary shall also have necessary assurance that the local organizations applying for aid have sufficient funds available to meet any obligations assumed under the agreement entered into.

History: L. 1965, ch. 291, § 3; June 30.

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(1) Each partner of a partnership;

(2) Each officer, director, and stockholder who has direct or indirect ownership or control of 10 percent or more of the stock of a corporation; or

(3) Each individual who has direct or indirect ownership of 10 percent or more of a nursing home.

(c) *Nursing home.* — "Nursing home" means a related institution that is classified as a nursing home. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from the first sentence of former Article 43, § 560B (a) and (a) (1) and (5).

Former Article 43, § 560B (a) (2), which defined "court" to specify courts in Baltimore City and the circuit court for any other county, is deleted as unnecessary in light of the reorganization of the Baltimore City courts.

Former Article 43, § 560B (a) (3), which defined "Director", is deleted as unnecessary since the full title "Director on Aging" is used in Part V of this subtitle.

Former Article 43, § 560B (a) (6), which defined "Secretary", is deleted as unnecessary in light of the definition of that term in § 1-101 of this article.

Former Article 43, § 560B (a) (7), which defined "transfer trauma", is deleted as unnecessary since that phrase did not appear in former Article 43, § 560B.

Defined term:

"Related institution"	§ 19-301

§ 19-334. Petitions for receivership.

(a) *Authorized.* — In addition to any other power set forth in this article or the Health Occupations Article, the Secretary may file a petition for appointment of a receiver for a nursing home if, after investigation of the Secretary or after investigation at the request of the Director on Aging, the Secretary reasonably believes that:

(1) A person is operating the nursing home without a license for it;

(2) The nursing home will be closed within 30 days and arrangements to relocate its residents have not been approved by the Secretary;

(3) The nursing home or its residents have been abandoned; or

(4) A situation, physical condition, practice, or method of operation presents an imminent danger of death or serious mental or physical harm to the residents of the nursing home.

(b) *Venue.* — A petition under this section shall be filed with the circuit court for the county where the nursing home is located. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from former Article 43, § 560B (a) (4), (c), (l), (m), and the first sentence of (b) (1).

In subsection (a) (1) of this section, the former specific reference to revocation of a license is deleted as unnecessary in light of the broad reference to operation without a license.

Subsection (a) (4) of this section is revised to incorporate the substance of former Article 43, § 560B (a) (4), which defined "emergency", since that term appeared infrequently in former Article 43, § 560B and, therefore, a separate definition of that term is not needed See also §§ 19-333 and 19-336 of this subtitle

Defined terms:

"County":	§ 1-101
"License"	§ 19-301
"Nursing home"	§ 19-333
"Person"	§§ 1-101 & 19-301
"Secretary"	§ 1-101

§ 19-335. Hearing requirements.

(a) *In general.* — (1) Except as otherwise provided in subsection (b) of this section, the court shall hold a hearing on a petition under Part V of this subtitle within 10 days after the petition is filed.

(2) The owner of the nursing home shall be given notice of the hearing:

(i) At least 5 days before the hearing; or

(ii) At least 3 days before the hearing, by a notice posted conspicuously inside or on the front door of the nursing home, if the Secretary files a statement that:

1. Is signed and verified by the Secretary;
2. States that the owner cannot be found; and
3. Sets forth a substantial account of reasonable, good faith efforts to find the owner and serve process.

(3) The owner of the nursing home is entitled to offer evidence at the hearing.

(b) *Ex parte order.* — (1) A court may appoint a receiver for a nursing home if, from the petition, affidavits, and any evidence offered ex parte, the court finds probable cause to believe that a situation, physical condition, practice, or method of operation presents an imminent danger of death or serious mental or physical harm to the residents of the nursing home and must be remedied immediately to insure their health, safety, and welfare.

(2) The owner or person then in charge of the nursing home shall be given notice of the appointment of a receiver:

(i) By service of the notice, within 24 hours after the appointment; or

(ii) By posting the notice conspicuously inside or on the front door of the nursing home, if the Secretary files a statement that:

1. Is signed and verified by the Secretary;
2. States that the owner and the person in charge of the nursing home cannot be found; and
3. Sets forth a substantial account of reasonable, good faith efforts to find the owner and the person in charge and serve process.

(3) Unless the owner of the nursing home consents to a later date, the court shall hold a hearing on the appointment of the receiver within 5 days after service of process. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from former Article 43, § 560B (a)(4), (d), and (b)(2), (3), and the second and third sentences of (1).

As to subsections (a)(2)(ii)1. and (b)(2)(ii)1 of this section and the word "verified", see § 1-201 of this article

In subsections (a)(3) and (b)(1) of this section.

the former references to "testimony" are deleted as unnecessary in light of the broad references to "evidence".

In subsection (b)(1) of this section, the former reference "without further hearing" is deleted as inconsistent with subsection (b)(3) of this section, which is derived from former Article 43, § 560B(d)(4). Subsection (b)(3) of this section is revised to clarify that this hearing is on the ex parte appointment of a receiver.

The Commission to Revise the Annotated Code notes, for consideration by the General Assembly, that subsection (a) of this section does not expressly allow for postponement of the hearing. Cf. subsection (b)(3) of this section.

Defined terms:

"Nursing home":	§ 19-333
"Person":	§§ 1-101 & 19-301
"Secretary":	§ 1-101

§ 19-336. Appointment of receiver; continuation of receivership.

(a) *In general.* — After the hearing under § 19-335 of this subtitle, the court may appoint a receiver for the nursing home or continue the appointment of the receiver made ex parte, if the court finds:

(1) A person is operating the nursing home without a license for it;

(2) The nursing home will be closed within 30 days and arrangements to relocate its residents have not been approved by the Secretary;

(3) The nursing home or its residents have been abandoned; or

(4) A situation, physical condition, practice, or method of operation presents an imminent danger of death or serious mental or physical harm to the residents of the nursing home.

(b) *Eligible individuals.* — The court may appoint as receiver any responsible individual other than:

(1) A State employee;

(2) An employee of a local government; or

(3) The owner or administrator of or other individual with a financial interest in the nursing home or agent of any of those individuals.

(c) *Bond.* — (1) Before the receiver takes charge of the nursing home, the receiver shall file a bond with the court.

(2) The bond:

(i) May not exceed the value of the nursing home and its assets; and

(ii) Shall run to this State for benefit of all persons interested in the faithful performance of the receiver.

(3) Unless the court directs otherwise, the receiver may pay the premium of the bond from the income of the nursing home.

(d) *Substitute receiver.* — The Secretary may petition the court to appoint a substitute for a receiver who:

(1) Dies;

(2) Has a disability;

(3) Has an adverse interest; or

(4) Does not make reasonable progress in carrying out the receivership. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from former Article 43, § 560B (a) (4), (e), (f), (h) (1), and (j).

In the introductory clause of subsection (a) of this section, the reference "continue the appointment of the receiver made ex parte" is added to state expressly the apparent intent of former Article 43, § 560B (d) (4), which provided for a hearing on the ex parte appointment. This revision clarifies that, while the ex parte appointment may be made only on the basis set forth in subsection (a) (4) of this section, the court could continue the appointment on any other basis set forth in subsection (a) of this section.

Subsection (c) (2) (ii) of this section is revised so that the bond runs to this State since the bond could not run to the nursing home.

Defined terms:

"License"	§ 19-301
"Nursing home"	§ 19-333
"Person"	§§ 1-101 & 19-301
"Secretary"	§ 1-101

§ 19-337. Powers and duties of receiver.

(a) *In general.* — (1) Except as expressly provided otherwise in this section, each receiver who is appointed under Part V of this subtitle has all of the powers of a receiver who is appointed under § 3-414 of the Corporations and Associations Article.

(2) The receiver shall perform all acts that are necessary and exercise the powers of the receiver to:

(i) Correct each condition on which the appointment of the receiver was based;

(ii) Ensure adequate care for each resident of the nursing home; and

(iii) Preserve the property of the owner of the nursing home.

(b) *Reports.* — The receiver shall report to the court as the court requires.

(c) *Care of residents.* — The receiver of a nursing home shall:

(1) Give each resident of the nursing home and the family of each resident notice of the receivership;

(2) Preserve all property of and records that relate to a resident of the nursing home and are in the custody of the receiver or the owner of the nursing home;

(3) If a resident is to be discharged or transferred from the nursing home:

(i) Explain to the resident or guardian of the resident the alternative placements that are available;

(ii) Help the resident or guardian of the resident to find an alternative placement;

(iii) Give information about the alternative placement chosen;

(iv) Transport the resident to the alternative placement; and

(v) Transfer all property of and records on the resident, including all necessary medical information, to the resident or the alternative placement.

(d) *Use of funds.* — The receiver of a nursing home may use:

(1) Any private or third party reimbursements to the nursing home, including any Medicaid or Medicare payments; and

(2) With the approval of the court, money from the special revolving fund established under § 19-338 of this subtitle.

(e) *Correction of violations.* — If the structure or furnishings of a nursing home violate State or federal law, the receiver of the nursing home may correct the violation:

(1) Without the consent of the court, if the cost of the correction does not exceed $3,000; or

(2) On petition to and with the consent of the court, if the cost of the correction is more than $3,000.

(f) *Contracts.* — (1) The receiver of a nursing home shall pay the principal of and interest on a mortgage or secured transaction unless the holder of the mortgage or the secured party is the owner of the nursing home or an affiliate of the owner.

(2) On petition of a receiver of a nursing home, the court may:

(i) Allow the receiver to avoid a lease, mortgage, secured transaction, or other contract that the owner of the nursing home made if:

1. The person seeking payment under the contract is or, at the time the contract was made, was the owner or an affiliate of the owner; and

2. The contract provides for a rent or interest rate substantially exceeding the rent or interest rate that was reasonable when the contract was made; and

(ii) If the receiver is allowed to avoid the contract, set a reasonable rent or interest rate to be paid on any property that is subject to the contract and is needed to continue operation of the nursing home.

(3) The court shall hold a hearing on a petition under this subsection within 15 days after the petition is filed.

(4) Notice of the petition shall be given to all known owners of property that the petition affects:

(i) By the receiver, at least 10 days before the hearing, or

(ii) By publication, if the receiver files with the court a statement that:

1. Is signed and verified by the receiver;

2. States that the owner of the property cannot be found, and

3. Sets forth a substantial account of reasonable, good faith efforts to find the owner and serve process.

(5) The court shall set a rent under this subsection in an amount that is not less than the total current payments of principal and interest required on all mortgages and secured transactions that:

(i) Affect the property under the contract to be avoided; and

(ii) Cannot be avoided under this subsection.

(6) Payment of the rent or interest rate that a court sets under this subsection is a defense in any action against the receiver for payment or for possession of the property. However, the payment does not relieve the owner of the nursing home of any liability for the difference between the amount that the receiver pays and the amount that is due under the contract.

(g) *Liability.* — (1) A receiver of a nursing home is not liable for an injury to person or property that results from the condition of the nursing home.

(2) A receiver only is liable for any act or omission that constitutes negligence in the fulfillment of the duties as receiver.

(h) *Fee.* — A receiver of a nursing home is entitled to the fee that the court finds reasonable. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from former Article 43, § 560B (e), (g), and (h) (2) and (3).

Subsection (d) (2) of this section is new language added as a general reference to the special fund.

As to subsection (f) (4) of this section and the word "verified", see § 1-201 of this article.

The Commission to Revise the Annotated Code notes, for consideration by the General Assembly, that it is unclear whether or not the receiver is personally liable under subsection (g) (2) of this section.

Defined terms:

"Affiliate"	§ 19-333
"Includes" "including":	§ 1-101
"Nursing home":	§ 19-333
"Person":	§§ 1-101 & 19-301
"Secretary":	§ 1-101

§ 19-338. Special fund.

(a) *"Fund" defined.* — In this section, "Fund" means the special revolving fund established under this section.

(b) *Fund established.* — (1) This State may establish a special revolving fund to provide financial support for a receiver of a nursing home.

(2) The amount of money in the Fund shall be at least $250,000 but not more than $500,000.

(c) *Uses of Fund.* — If, after a receiver uses all private and third party payments to the nursing home, expenses remain unpaid, the receiver may petition the court for money from the Fund.

(d) *Hearing required.* — (1) Before a court authorizes use of money from the Fund, the court shall hold a hearing.

(2) Notice of the hearing shall be given to the receiver and the owner of the nursing home at least 7 days before the hearing.

(3) At the hearing, the receiver and owner of the nursing home may offer evidence on whether the court should approve a loan.

(e) *Repayment.* — The Secretary shall determine the repayment schedule for a loan from the Fund.

(f) *Lien.* — (1) A loan from the Fund is a lien on the nursing home and its assets if the receiver files a notice of the lien that contains:

(i) The amount of the lien;

(ii) The name of the nursing home to which the lien attaches; and

(iii) A description of the assets of the nursing home that are affected by the lien.

(2) The receiver shall file the notice of lien with:

(i) The land and chattel records of the county where the nursing home is located; and

(ii) The Department of Assessments and Taxation.

(3) A lien under this subsection:

(i) Extends to:

1. The property of a nursing home that is described in the notice of lien; and

2. The beneficial interest of the owner or affiliate of a nursing home in that property; and

(ii) Has priority over any lien or other interest that attaches after the date of the completion of the filings required under this subsection. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

Subsection (a) of this section is new language added to avoid repetition.

Subsections (b) through (f) of this section are new language derived without substantive change from the first, second, fourth, and fifth sentences of former Article 43, § 560B (k) (1) and the first, second, fourth, fifth, and sixth sentences of (2).

In subsection (d) (3) of this section, the former reference to "testimony" is deleted in light of the broad reference to "evidence".

The third sentence of former Article 43, § 560B (k) (1), which provided that "[t]he special revolving fund shall be funded by the State out of the State funds allocated for that purpose", is deleted as unnecessary.

The third sentence of former Article 43, § 560B (k) (2), which provided that no lien shall exist until notice of lien is filed, is deleted as unnecessary in light of subsection (f) (1) of this section.

Defined terms:

"Affiliate":	§ 19-333
"Nursing home":	§ 19-333
"Secretary":	§ 1-101

§ 19-339. Termination of receivership.

(a) *Petition for termination.* — (1) The owner or receiver of a nursing home may petition the court to terminate the receivership.

(2) The court shall terminate the receivership and return the nursing home to its owner, if the court finds:

(i) The grounds for appointment of the receiver under Part V of this subtitle no longer exist; or

(ii) The nursing home is ready to be closed because all residents of a nursing home have been moved from the nursing home.

(b) *Automatic termination.* — A receivership ends automatically 1 year after the court appoints the receiver, unless the court:

(1) Terminates the receivership sooner; or

(2) On petition of the Secretary, extends the receivership for an additional 1-year period because the court finds that the grounds for appointment of a receiver under Part V of this subtitle still exist.

(c) *Effect of sale of nursing home.* — The sale of a nursing home or any of its assets does not terminate a receivership of the nursing home. (An. Code 1957, art. 43, § 560B; 1982, ch. 21, § 2.)

REVISOR'S NOTE

This section is new language derived without substantive change from former Article 43, § 560B (i).

Defined terms:

"Nursing home":	§ 19-333
"Secretary":	§ 1-101

§§ 19-340, 19-341.

Reserved.

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Public Health
Division of Health Care Quality
150 Tremont Street
Boston 02111

BAILUS WALKER, Jr. Ph. D, M.P.H.
Commissioner

October 24, 1985

Lucia Divenere
Senate Special Committee on Aging
S.D.G. 33
Washington, D.C. 20510

RE: Nursing Home Receiverships

Dear Lucia:

I enjoyed our discussion last week. I am sending you some material which may be helpful to the Committee in its consideration of the Federal role in nursing home receivership cases.

From the perspective of Medicare/Medicaid patients victimized by the neglect and harm associated with gross deficiencies, it is particularly important to foster the implementation of an effective patient care receivership program. Unfortunately conscientious patient advocates, family members, and State and Federal health care officials can face a cruel choice between acknowledging serious problems which can result in the termination of funds and facility closure, and postponing major enforcement action in the hope that some form of moderate compliance will eventually occur.

Receivership can be an extremely effective patient protection remedy in a jeopardy case. An effective receivership action generally includes the following elements:

1. Swift identification and documentation of gross deficiencies which imperil patient safety. For example, comprehensive deficiency statements, affidavits from surveyors describing neglect and mistreatment with particularity, and an affidavit or finding by a physician who validates the jeopardy conclusion. (Refer to Attachments A, B, and C which pertain to a recent receivership action involving a chronic hospital in Massachusetts.)

2. The initiation of legal action against the nursing home operator which includes a request for the court appointment of a receiver. (Refer to Attachment D which is an example of a complaint seeking a receiver, and Attachment E which is a copy of the Massachusetts Receivership Statute.)

3. The appointment of a receiver who possesses clear authority to manage and operate the nursing home, receive reimbursement funds, remedy deficiencies, and hire and fire employees. (Refer to Attachment F which is a typical order of appointment.)

4. Concerted action by the receiver and the State agencies in addressing priority deficiency problems within 15-30 days.

5. Administrative action by the State agency to either delicense or decertify the unsuitable operator who was responsible for the jeopardy. (Refer to Attachment G.)

6. Adoption of a specific policy for receivership case aimed at either a) seeking a suitable new owner within 3-6 months to operate the facility, or b) in the event a sale is impossible or a facility is not viable, to execute a careful patient relocation process which prevents "transfer trauma". (Refer to Attachment H.)

This year the Massachusetts Department of Public Health and the Department of the Attorney General have sought and obtained the appointment of receivers in five cases. We have also provided technical support to several States which have expressed a interest in receivership actions. (Refer to Attachments I, J, K and L.)

There is an important role for Federal government, and the Department of Health and Human Services in this area. HHS should encourage or require States to develop and implement receivership programs in true jeopardy cases. To the extent that States can demonstrate that a receiver has effectively addressed jeopardy deficiencies in a particular case, HHS should provide FFP to assure continued operation and eventual recertification (to a suitable new operator). HHS can also require States to establish mechanisms regarding the reporting and investigation of patient abuse, (refer to Attachments M, N, O, and P) and the screening of nursing home applicants on the basis of patient care performance. (Refer to Attachment Q.)

I hope these suggestions are useful. Do not hesitate to contact me if you have any additional questions or concerns.

Finally I recommend that you contact Mark Muldoon, Esq., Medicaid Fraud and Abuse Unit, Department of the Attorney General at (617) 727-2823) regarding questions relating to Medicaid discrimination.

Sincerely,

David Roush

David Roush, Esq.
Assistant Director for Compliance

DR:emk
Attachments

EXHIBIT
Receivership Statute

MGL c.11 ss 72M-T

"The provisions of this act are severable and the invalidity of any section shall not affect the continuing validity of any other of said sections."

§ 72M. Appointment of receiver; emergency; definition

The superior court department of the trial court, upon petition of the attorney general or upon petition of the department or any interested party, as hereinafter provided, shall appoint a receiver for any institution subject to licensing under section seventy-one, hereinafter called a facility, provided that the court finds that an emergency exists or that the facility is operating without a license or without a valid, completed application for licensure on file with and awaiting action by the department, or the department has denied, revoked or refused to renew a license, or has initiated license denial, revocation or nonrenewal procedures and the lives, health, safety or welfare of the residents cannot be adequately assured pending the full hearing and decision on the matter.

As used in this section "emergency" shall mean a situation or condition which presents imminent danger of death or serious physical harm to patients, including but not limited to imminent or actual abandonment of an occupied facility, and excluding a crisis due solely to a natural disaster beyond the control of the licensee where the licensee is taking appropriate remedial steps. An organized labor activity conducted for union recognition or as a tactic in contract negotiations shall not, of itself, constitute an emergency. Voluntary withdrawal from participation as a provider of services under the medical care and assistance program, established under chapter one hundred and eighteen E, or under the program of health insurance for the aged and disabled established under Title XVIII of the Social Security Act (P.L. 89-97)[1] where such withdrawal was not occasioned by the denial of certification to the facility, shall not, of itself, constitute an emergency.

Added by St.1981, c. 528, § 3.

[1] 42 U.S.C.A. § 1395 et seq.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

Library References

Asylums 🔑3.
C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

§ 72N. Action to appoint receiver; hearing; list of persons; purpose of receivership; stay of actions

The department or the attorney general may bring an action in the superior court department of the trial court requesting the appointment of a receiver to operate a facility. Before the department brings such an action, a nursing home administrator designated by the commissioner shall be informed that the department intends to bring such an action and shall be informed of the reasons for the decision to bring such an action. Said administrator shall be duly licensed according to the provisions of section one hundred and eleven of chapter one hundred and twelve of the General Laws and shall have at least five years experience as a nursing home administrator. Said administrator may submit his recommendations concerning the facility proposed for receivership within two business days after receiving the above information. After said two-day period, the department, in its sole discretion may bring an action in the superior court department described in this section. A resident or guardian of a resident may petition the department or the attorney general to seek a receivership under this section. If the department or attorney general denies such petition or fails to commence action within five days, the party bringing the petition may bring suit in the superior court department for the appointment of a receiver or other appropriate relief under this section. Upon filing of the suit, a resident or guardian shall serve a copy of the complaint on the department. Prior to any hearing for the appointment of a receiver, the department shall file, and the court shall consider, an affidavit made under oath describing the results of any investigation conducted by the department, including a statement of any findings with respect to the resident's petition and the reasons for not filing an action pursuant to this section, and shall append thereto the two most recent reports of deficiencies in that facility. Nothing in this chapter shall be construed as abrogating or superseding any common law or statutory right of any person to bring an action requesting appointment of a receiver to operate a facility.

The department may, in its sole discretion, in addition to or in lieu of bringing an action hereunder, assist a licensee in seeking a rate adjustment or other relief from the rate setting commission.

The court shall issue a short order of notice and, where an emergency is alleged, set the matter for hearing within five days after filing of the action. In all other cases, a hearing shall be set within two weeks. A receiver shall be appointed immediately, on an ex parte basis, if it appears by verified complaint or by affidavit that there are grounds for the appointment of a receiver and that immediate appointment is necessary to prevent harm to the residents.

The court may appoint as a receiver any person appearing on a list established for the purpose by the commissioner and the secretary of elder affairs after consultation with representatives of the nursing home industry. Persons appearing on said list shall have experience in the delivery of health care services, and, if feasible, shall have experience with the operation of long term care facilities.

The purpose of a receivership created under this section shall be to safeguard the health, safety and continuity of care to residents and to protect them from the adverse health effects and increased risk of death caused by abrupt or unsuitable transfer. A receiver appointed hereunder shall not take any actions or assume any responsibilities inconsistent with this purpose.

No person shall impede the operation of a receivership created under this section. There shall be an automatic stay for a sixty-day period subsequent to the appointment of a receiver, of any action that would interfere with the functioning of the facility, including but not limited to cancellation of insurance policies executed by the licensee, termination of utility services, attachments or set-offs of resident trust funds and working capital accounts, and repossession of equipment used in the facility.

Added by St.1981, c. 528, § 3.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

§ 72O. Authority of receiver; duties; closure of facility; repairs; financial assistance

When a receiver is appointed, the licensee shall be divested of possession and control of the facility in favor of the receiver. With the approval of the court, the receiver shall have authority to remedy violations of federal and state law and regulations governing the operation of the facility; to hire, direct, manage and discharge any consultant or employees, including the administrator of the facility; to receive and expend in a reasonable and prudent manner the revenues of the facility; to continue the business of the facility and the care of the residents; to perform those acts necessary or desirable to accomplish the purpose of the receivership; to perform regular accountings and make periodic reports to the court; and to exercise such additional powers and perform such additional duties, as the court may deem appropriate.

The receiver shall apply the current revenues of the facility to current operating expenses and, subject to the following provisions, to debts incurred by the licensee prior to the appointment of the receiver. The receiver shall ask the court for direction in the treatment of debts incurred prior to this appointment where such debts appear extraordinary, of questionable validity, or unrelated to the normal and expected maintenance and operation of the facility, or where payment of such debts will interfere with the purposes of the receivership. Priority shall be given by the receiver to expenditures for current, direct resident care, including nursing care, social services, dietary services, and housekeeping.

Revenues held by or owing to the receiver in connection with the operation of the facility shall be exempt from attachment and trustee process. Any retroactive payment that may be due or owing to the facility as the result of a retroactive rate adjustment shall be disposed of in accordance with the orders of the court, after it considers competing claims to said payments.

The receiver shall not close the facility without leave of court. In ruling on the issue of closure, the court shall consider the best interest of the residents and the possibility of transferring them to suitable, alternative placements; the rights, interests and obligations of the licensee, the owner, the mortgagees, and other secured parties and lienholders; the licensure status of the facility; the condition of the real estate with respect to state and federal construction requirements and any other factor which the court deems relevant.

If the court has approved closure of the facility, the receiver shall make major repairs to the real or personal property of the facility but only to the extent necessary to prevent or remove jeopardy to the health, safety or welfare of the residents. If the court has not directed closure of the facility, the receiver may make such repairs but only to the extent necessary to prevent or remove jeopardy to the health, safety or welfare of the residents or to minimally qualify the facility for continuing participation in the medical care and assistance programs, established under chapter one hundred and eighteen E, or in the program of health insurance for the aged and disabled under Title XVIII of the Social Security Act (P.L.—89-97).[1]

In the event that a receiver appointed under section seventy-two N does not have sufficient capital to advance for major repairs or improvements, the receiver may petition the court for permission to apply to the department for a loan. Notice shall be given to the owner of the real estate, the licensee, the department, and to any mortgagee and other secured parties and lienholders of record. The court shall after hearing, authorize the receiver to apply for such assistance if it determines that the facility should not be closed, and the commissioner certifies that the repair or improvement is necessary to prevent or remove jeopardy to patients or to minimally qualify the facility for participation in said medical care and assistance program and said program of health insurance for the aged and disabled; or it determines that the facility should be closed and the commissioner certifies that the repair or improvement

is necessary to prevent jeopardy to residents for the limited period of time that they are awaiting transfer. The purposes of this provision shall be to protect residents and to prevent the closure of facilities which, given proper management, are likely to be viable operations. This section shall not be construed as a method of financing major repairs or capital improvements to facilities which have been abandoned because the licensee has been unable to secure financing by conventional means.

Upon court approval, application for financial assistance shall be made to the department, which shall administer such funds as the legislature may appropriate for this purpose. The court may set a reasonable rate of interest to be paid by the receiver to the department.

The licensee or the owner may apply to the court to determine the reasonableness of any expenditure by the receiver.

Except as provided in section seventy-two Q and in section thirty-two A of chapter six A, a receiver appointed pursuant to this chapter shall be subject to the same rules and regulations of the rate setting commission which govern other providers of long term care services.

Added by St.1981, c. 528, § 3.

[1] 42 U.S.C.A. § 1395 et seq.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

§ 72P. Leases, mortgages or secured transactions; avoidance; setting of rental or interest rate; hearing; foreclosure

A receiver shall not be required to honor any lease, mortgage, or secured transaction entered into by the licensee of the facility if the court finds that the agreement was entered into for a fraudulent purpose or to hinder or delay creditors or that the rental, price or rate of interest required to be paid under the agreement is in excess of a reasonable rental, price or rate of interest at the time the agreement was entered into; or the agreement is unrelated to the operation of the facility.

If the receiver is in possession of real or personal property subject to a lease, mortgage or security interest which the receiver is permitted to avoid, and if the possession of said property is necessary for the continued operation of the facility the receiver shall apply to the court to set a reasonable rental, price or rate of interest to be paid by the receiver to the person entitled thereto during the duration of the receivership. The court shall hold a hearing on the application within fifteen days. The receiver shall send notice of the application to any owners of record and to mortgagees and other secured parties and lienholders of record of the property involved at least ten days prior to the hearing. In no event shall the amount set by the court exceed what is reasonable for the facility in light of the usual regulations of the rate setting commission and the private census of the facility. Payment by the receiver of the amount determined by the court to be reasonable shall be a defense to any action against the receiver for payment or for the possession of said property subject to the lease, mortgages or security interest involved by any person who received such notice.

Notwithstanding the foregoing, there shall be no foreclosure or eviction during the receivership period where such foreclosure or eviction would, in the view of the court, serve to defeat the purpose of the receivership.

Added by St.1981, c. 528, § 3.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

§ 72Q. Compensation of receiver; bond; lien; recoupment of commonwealth expenditures

The court shall set a reasonable compensation for the receiver that is consistent with the regulations of the rate setting commission, and shall require the receiver to furnish a bond. Such expenses shall be paid from the revenues of the facility.

The licensee shall be liable for any adjustment to the facility's rate that is necessitated by the provisions of the first paragraph of this section.

The commonwealth shall have a lien for any expenditure under section seventy-two *O* upon the following property: the building in which the facility is located; the land on which the facility is located; any fixtures, equipment or goods used in the operation of the facility. Such lien shall be prior to any mortgage or lien which the court finds has been executed or obtained for a fraudulent purpose or to hinder or delay creditors. Such lien shall also be prior to a mortgage or lien held by any person with an ownership interest in the facility; or any person which controls or has the ability to directly or indirectly control to any significant degree the management of policies of the licensee or the facility; or any person related to the licensee or to the facility by any significant degree of common ownership or common control. The receiver shall cause notice of any lien created hereunder to be duly filed.

As an additional remedy for recouping commonwealth expenditures, the licensee, persons responsible for the affairs of the licensee, or the owner, may be held liable for such expenditures to the extent that any of these persons benefits financially from the expenditure. Recoupment shall also be available against any person who, prior to the appointment of the receiver, breached a legal responsibility to assure appropriate maintenance of the facility, if such breach necessitated the expenditure by the commonwealth, and against any person who was responsible for an abandonment of the facility.

Added by St.1981, c. 528, § 3.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

§ 72R. Termination of receivership

A receivership shall not be terminated if a license to operate the facility would not be in effect upon termination; or the facility would revert to the licensee during the pendency of proceedings to revoke, deny, or suspend its license; or the facility would revert to a person not approved for licensure by the department.

The court may terminate a receivership under the following conditions: the department grants a license to operate the facility to the licensee divested of possession and control by the receiver; or there is a transfer of ownership of the facility to a transferee approved for licensure by the department; or all residents of the facility have been provided appropriate alternative placements, either in another facility or otherwise, and the subject facility is closed.

Notwithstanding the provisions of the second paragraph, a receivership shall not be terminated in favor of the former licensee, or, in the discretion of the court, a related person, unless such person first makes restitution to the department of public welfare of any rate increases for the receiver's compensation paid to the facility pursuant to section thirty-two A of chapter six A and such person repays the department of any amount that it may have paid to the receiver as a loan for major repairs or improvements of the facility, or assumes the obligation to repay the loan and provides collateral or other assurance of payment deemed sufficient by the department.

As an additional precondition to termination in favor of the former licensee, or in the discretion of the court, a related person, the court may require the posting of a bond in an amount fixed by the court as security for maintaining compliance with the laws and regulations governing the operation of the facility. If it shall appear that the licensee fails to maintain the facility in substantial compliance with such laws and regulations, the court, after notice to those persons who have appeared in the proceeding, and after hearing, shall reinstate its order appointing a receiver. A receiver thus appointed may use the security, or such part of the security as is necessary, to remedy the deficient conditions. A receivership thus reinstated shall be terminated only upon transfer of the facility to a purchaser approved by the department and the court, or upon closure of the facility.

If the receivership has not been terminated within twelve months of the appointment of the receiver, the court shall, after hearing, order either that the facility shall be closed, after an orderly transfer of the residents to appropriate alternative placements; or the facility shall be sold, under reasonable terms approved by the court, to a new owner approved for licensure by the department. The receivership period may be extended as necessary to protect the health and safety of the residents.

Added by St.1981, c. 528, § 3.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

§ 72S. Actions against receiver; liability

No person shall bring an action against a receiver appointed under section seventy-two N without first securing leave of court. The receiver shall be liable in his personal capacity for gross negligence or intentional wrongdoing. In all other cases, the receiver shall be liable in his official capacity only, and any judgment rendered shall be satisfied out of the receivership assets.

Added by St.1981, c. 528, § 3.

Historical Note

St.1981, c. 528, § 3, was approved Nov. 9, 1981. Emergency declaration by the Governor was filed Nov. 10, 1981.

§ 72T. Effect of appointment; violation of regulations

An order appointing a receiver under section seventy-two N shall have the effect of a license for the duration of the receivership. The receiver shall be responsible to the court for the conduct of the facility during the receivership, and any violation of regulations governing the conduct of the facility, if not promptly corrected, shall be reported by the department to the court.

Added by St.1981, c. 528, § 3.

~~Mo. B~~ Vernon's Annotated Mo. Stat. § 198.099 +(supp)

3. Whenever the director determines that the amount of any bond which is filed pursuant to this subsection is insufficient to adequately protect the money of residents which is being handled, or whenever the amount of any such bond is impaired by any recovery against the bond, the director may require the operator to file an additional bond in such amount as necessary to adequately protect the money of residents being handled.

4. In the event that any such bond includes a provision allowing the surety to cancel after notice, the bond shall provide for a minimum of sixty days' notice to the department.

(L.1979, p. 406, § 32.)

Library References

Asylums 🔑5.

C.J.S. Asylums and Institutional Care Facilities §§ 11, 12.

198.099. Petition for appointment of receiver—when

The attorney general, either on his own initiative or upon the request of the department or of any other state governmental agency having an interest in the matter, a resident or residents or the guardian of a resident of a facility or the owner or operator of a facility may petition for appointment of a receiver for a facility when any of the following conditions exist:

(1) The operator is operating without a license;

(2) The department has revoked the license of an operator or refused to grant an application for a license to the operator;

(3) The department has initiated revocation procedures and has determined that the lives, health, safety, or welfare of the residents cannot be adequately assured pending a full hearing on license revocation;

(4) The facility is closing or intends to close and adequate arrangements for relocation of residents have not been made at least thirty days prior to closure;

(5) An emergency exists in the facility;

(6) The operator is insolvent; or

(7) An owner of the land or structure is insolvent and such insolvency substantially affects the operation of the facility.

(L.1979, p. 406, § 33.)

Library References

Receivers 🔑22.

C.J.S. Receivers §§ 36, 42 to 47.

29, 1980, and filed suit on April 21, 1981, all statutory deadlines were met and no limitation problem was present. Stiffelman v. Abrams (Sup.1983) 655 S.W.2d 522.

198.099. Petition for appointment of receiver—when

Notes of Decisions

1. In general

Private remedy given by section of Omnibus Nursing Home Act for deprivation of patients' right to be free from abuse coexists with array of governmental devices, such as injunctions, civil penalty, and receivership, as well as ultimate sanction of license revocation. Stiffelman v. Abrams (Sup.1983) 655 S.W.2d 522.

198.105. Petition for appointment of receiver, contents—hearing—appointment of receiver

Any petition for appointment of a receiver shall be verified and shall be accompanied by an affidavit or affidavits setting forth material fact showing there exists one or more of the conditions specified in section 198.099. The petition shall be filed in the circuit court of Cole County or in the county where the facility is located. If the petition is not filed by the attorney general, a copy of the petition shall be served upon the department and upon the attorney general. The court shall hold a hearing on the petition within five days of the filing of the petition and determine the matter within fifteen days of the initial hearing. The petition and notice of the hearing shall be served on the operator or administrator of the facility or, if personal service is impossible, shall be posted in a conspicuous place in the facility not later than three days before the time specified for the hearing, unless a different period is fixed by order of the court. The court shall appoint the director of the department or his designee, or any person determined by the court to be qualified, to act as receiver if it finds that any ground exists which would authorize the appointment of a receiver under section 198.099 and that appointment of a receiver will contribute to the continuity of care or the orderly and safe transfer of residents in the facility.

(Amended by L.1984, p. —, S.B. No. 451, § 1.)

1984 Amendment. Inserted "and determine the matter within fifteen days of the initial hearing" in the fourth sentence of the section.

NURSING HOME DISTRICTS

198.200. District created, how—territory included—name—nursing home defined

1. A nursing home district may be created, incorporated and managed as provided in sections 198.200 to 198.350 and may exercise the powers herein granted or necessarily implied. A nursing home district may include municipalities or territory not in municipalities or both or territory in one or more counties; except, that the provisions of sections 198.200 to 198.350 are not effective in counties having a population of more than four hundred thousand inhabitants. The territory contained within the corporate limits of an existing nursing home district shall not be incorporated in another nursing home district.

2. When a nursing home district is organized it shall be a body corporate and political subdivision of the state and shall be known as "... Nursing Home District", and in that name may sue and be sued, levy and collect taxes within the limitations of sections 198.200 to 198.350 and the constitution and issue bonds as herein provided.

3. For the purposes of sections 198.200 to 198.360, "nursing home" shall mean a residential care facility I, a residential care facility II, an intermediate care facility, or a skilled nursing facility as defined in section 198.006.

(Amended by L.1984, p. —, S.B. No. 451, § 1.)

Minnesota Stat. Ann.

make a reply within seven days after he receives it to the complaining resident stating that the complaint did not constitute a valid objection to the nursing home's operations, shall be a violation of section 144A.10. If a complaint directly involves the activities of a nursing home administrator, the complaint shall be resolved in accordance with this section by a person, other than the administrator, duly authorized by the nursing home to investigate the complaint and implement any necessary corrective measures.

Subd. 2. Resident's rights. The administrator of a nursing home shall inform each resident in writing at the time of admission of his right to complain to the administrator about facility accommodations and services. A notice of the right to complain shall be posted in the nursing home. The administrator shall also inform each resident of his right to complain to the commissioner of health. No controlling person or employee of a nursing home shall retaliate in any way against a complaining nursing home resident and no nursing home resident may be denied any right available to him under Minnesota Statutes, Chapter 566.

Laws 1976, c. 173, § 13. Amended by Laws 1977, c. 305, § 45, eff. May 28, 1977.

Effective date. See section 144A.01, note.

144A.14. Voluntary receivership

A majority in interest of the controlling persons of a nursing home may at any time request the commissioner of health to assume the operation of the nursing home through appointment of a receiver. Upon receiving a request for a receiver, the commissioner of health may, if it deems receivership desirable, enter into an agreement with a majority in interest of the controlling persons, providing for the appointment of a receiver to take charge of the facility under conditions deemed appropriate by both parties. The agreement shall specify all terms and conditions of the receivership and shall preserve all rights of the facility residents as granted by law. A receivership initiated in accordance with this section shall terminate at the time specified by the parties or at the time when either party notifies the other in writing that he wishes to terminate the receivership agreement.

Laws 1976, c. 173, § 14. Amended by Laws 1977, c. 305, § 45, eff. May 28, 1977.

Effective date. See section 144A.01, note.

144A.15. Involuntary receivership

Subdivision 1. Petition, notice. In addition to any other remedy provided by law, the commissioner of health may petition the district court in Ramsey county or in the district in which a nursing home is located for an order directing the controlling persons of the nursing home to show cause why the commissioner of health or its designee should not be appointed receiver to operate the facility. The petition to the district court shall contain proof by affidavit that the commissioner of health has either commenced license suspension or revocation proceedings, suspended or revoked a license, or decided not to renew the nursing home license. The order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy to the nursing home administrator and to the persons designated as agents by the controlling persons to accept service on their behalf pursuant to section 144A.03, subdivision 2.

Subd. 2. Appointment of receiver, rental. If, after hearing, the court finds that involuntary receivership is necessary as a means of protecting the health, safety or welfare of a resident of a nursing home, the court shall appoint the commissioner of health, or any other person designated by the commissioner of health, as a receiver to take charge of the facility. The court shall determine a fair monthly rental for the facility, taking into account all relevant factors including the condition of the facility. This rental fee shall be paid by the receiver to the appropriate controlling persons for each month that the receivership remains in effect. Notwithstanding any other law to the contrary, no payment made to a controlling person by any state agency during a period of involuntary receivership shall include any allowance for profit or be based on any formula which includes an allowance for profit.

Subd. 3. Powers and duties of receiver. A nursing home receiver appointed pursuant to this section shall with all reasonable speed, but in any case, within 18 months after the receivership order, provide for the orderly transfer of all the nursing home's residents to other facilities or make other provisions for their continued safety and health care. The receiver may correct or eliminate those deficiencies in the facility which seriously endanger the life, health or safety of the residents unless the correction or elimination of deficiencies involves major alterations in the physical structure of the nursing home. He shall, during this period, operate the nursing home in a manner designed to guarantee the safety and adequate health care of the residents. The receiver shall take no action which impairs the legal rights of a resident of the nursing home. He shall have power to make contracts and incur lawful expenses. He shall collect incoming payments from all sources and apply them to the cost incurred in the performance of his functions as receiver. No security interest in any real or personal property comprising the nursing home or contained within it, or in any fixture of the facility, shall be impaired or diminished in priority by the receiver. The receiver shall pay all valid obligations of the nursing home and shall deduct these expenses, if appropriate, from rental payments owed to any controlling person by virtue of the receivership.

Subd. 4. Receiver's fee; liability; commissioner assistance. A nursing home receiver appointed pursuant to this section shall be entitled to a reasonable receiver's fee as determined by the court. The receiver shall be liable only in his official capacity for injury to person and property by reason of the conditions of the nursing home. He shall not be personally liable, except for his gross negligence and intentional acts. The commissioner of health shall assist the receiver in carrying out his duties.

Subd. 5. Termination. An involuntary receivership imposed pursuant to this section shall terminate 18 months after the date on which it was ordered or at any other time designated by the court or upon the occurrence of any of the following events:

(a) A determination by the commissioner of health that the nursing home's license should be renewed or should not be suspended or revoked;

(b) The granting of a new license to the nursing home; or

(c) A determination by the commissioner of health that all of the residents of the nursing home have been provided alternative health care, either in another facility or otherwise.

Laws 1976, c. 173, § 15. Amended by Laws 1977, c. 305, § 45, eff. May 28, 1977.

Effective date. See section 144A.01, note.

144A.16. Cessation of operations

If a nursing home plans to cease operations or to curtail operations to the extent that relocation of residents is necessary, the controlling persons of the facility shall notify the commissioner of health at least 90 days prior to the scheduled cessation or curtailment. The commissioner of health shall cooperate with and advise the controlling persons of the nursing home in the resettlement of residents. Failure to comply with this section shall be a violation of section 144A.10.

Laws 1976, c. 173, § 16. Amended by Laws 1977, c. 305, § 45, eff. May 28, 1977.

Effective date. See section 144A.01, note.

New Jersey

Effective date, see note under § 26:2H-32.

IV. MAINTENANCE OF STANDARDS IN BOARDING OR NURSING HOMES

26:2H-36. Legislative findings

The Legislature finds:

a. Many senior citizens in the State are residing in boarding homes or nursing homes. Their life, safety, health and welfare is largely dependent upon the conditions and care provided in these homes;

b. Some homes are providing inadequate medical and nursing care, inadequate living conditions, and are in substantial or habitual violation of Federal or State laws or regulations concerning health, safety or resident care;

c. It is necessary in order to protect the public welfare and the residents of the homes that a summary statutory procedure be established to eliminate substantial or habitual deficiencies in resident care or living conditions or violations of Federal or State laws or regulations in these homes.

L.1977, c. 238, § 1, eff. Sept. 29, 1977.

Assembly Institutions, Health and Welfare Committee Statement

Senate, No. 1544—L.1977, c. 238

When standards of health, safety or resident care in nursing homes and boarding homes are substantially and persistently violated, the only present alternatives are to revoke the home's license—which closes the home and forces patients to undergo the trauma of movement to new quarters—or Medicaid decertification—which results in the loss of an already limited number of beds for Medicaid recipients.

This bill provides a third alternative—one which would neither impose hardship on residents of homes nor decrease the number of Medicaid beds. Under its provisions, a home determined to be deficient in standards and services would continue to operate, but under a temporary receivership which would provide for the improvement of services.

* * * * * *

Title of Act:

An Act promoting the health, safety and welfare of residents in certain health care facilities. L.1977, c. 238.

Administrative Code References

Long-term care facilities, see N.J.A.C. 8:31-12.1.

Manual of standards for boarding homes for sheltered care, see N.J.A.C. 8:31-7.1.

Manual of standards for licensure of long-term care facilities, see N.J.A.C. 8:39-1.1 et seq.

Manual of standards for new boarding homes for sheltered care, see N.J.A.C. 8:43-1.1 et seq.

Cross References

Ombudsman for institutionalized elderly, see § 52:27G-1 et seq.

Library References

Asylums ⇐3.

C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

26:2H-37. Definitions

As used in this act, and unless the context otherwise requires:

a. "Boarding or nursing home" or "home" means a private nursing home or convalescent home regulated under chapter 11 of Title 30 of the Revised Statutes or a facility or institution, private or public, regulated and licensed as an extended care facility, skilled nursing home, nursing home or intermediate care facility pursuant to P.L.1971, c. 136 (C. 26:2H-1 to 26:2H-26) or a ~~boarding home, rest home or other home for sheltered care of adult persons~~ residential health care facility, as defined in section 1 of P.L.1953, c. 212 (C. 30:11A-1) or licensed pursuant to P.L.1971, c. 136 (C. 26:2H-1 to 26:2H-26).

b. "Owner" means the holder or holders of the title in fee simple to the property on which the home is located.

c. "Licensee" means the holder or holders of a license to operate a boarding or nursing home pursuant to chapter 11 of Title 30 of the Revised Statutes, P.L.1953, c. 212 (C. 30:11A-1 to 30:11A-14) or P.L.1971, c. 136 (C. 26:2H-1 to 26:2H-26).

d. "Department" means the State Department of Health.

L.1977, c. 238, § 2, eff. Sept. 29, 1977. Amended by L.1979, c. 496, § 24.

1979 amendment effective 180 days after Feb. 29, 1980, see note under § 55:13B-1.

Library References

Words and Phrases (Perm. Ed.)

26:2H-38. Remedy of condition of home in substantial violation of standards of health, safety or resident care; action to appoint receiver; parties

A proceeding by the State Department of Health, or any other State governmental agency having an interest in the matter, a resident or residents or the guardian of a resident of a boarding or nursing home for a judgment directing the appointment of a receiver for the purposes of remedying a condition or conditions of a home in substantial violation of the standards of health, safety or resident care established under Federal or State law or regulations or of remedying a pattern and practice of habitual violations of the standards of health, safety or resident care established under Federal or State law or regulations may be maintained in a court of competent jurisdiction. If the action is not brought by the department, a copy of the complaint shall be served upon it.

L.1977, c. 238, § 3, eff. Sept. 29, 1977.

Cross References

Nursing home responsibilities and rights of residents, see § 30:13-1 et seq.

26:2H-39. Complaint; contents

The complaint shall:

a. (1) Set forth material facts showing that there exists in the boarding or nursing home a condition or conditions in substantial violation of the standards of health, safety or resident care established under Federal or State law or regulations or any other conditions dangerous to life, health or safety or (2) that there exists in the boarding or nursing home a pattern and practice of habitual violation of the standards of health, safety or patient care established under Federal or State law or regulations.

b. Set forth that the facts set forth in subsection a. of this section have been brought to the attention of the owner and licensee of the home and that the condition or conditions have not been remedied within a reasonable period of time or that the condition or conditions although periodically remedied habitually exists in the home as pattern and practice.

c. Set forth a brief description of what is necessary to remedy the condition and an estimate of the cost thereof.

d. State the relief sought.

L.1977, c. 238, § 4, eff. Sept. 29, 1977.

26:2H-40. Defenses

It shall be a sufficient defense to the proceeding if the owner or licensee establishes that the condition or conditions alleged in the complaint do not in fact exist or that such condition or conditions have been removed or remedied or that such condition or conditions, although periodically remedied, have not habitually existed as pattern and practice.

L.1977, c. 238, § 5, eff. Sept. 29, 1977.

26:2H-41. Summary proceeding; judgment

The court shall proceed in a summary manner and shall render a judgment either:

a. Dismissing the complaint for failure to affirmatively establish the allegations thereof or because of the affirmative establishment by the owner or licensee of a defense specified in this act; or

b. Ordering the appointment of a receiver in accordance with the provisions of this act; or

c. Granting such other and further relief as the court deems just and proper.

L.1977, c. 238, § 6, eff. Sept. 29, 1977.

26:2H-42. Receiver; qualifications; duties and powers

a. The court is authorized and empowered to appoint as a receiver any responsible person or persons except that no owner, licensee or administrator of the home shall be appointed as receiver.

b. The receiver, in his discretion, may either (1) assume the role of administrator or manager and take control of all day-to-day operations, or (2) direct the administrator or manager on actions and procedure to be taken to eliminate or rectify the conditions specified in the complaint.

c. With the approval of the court the receiver shall have any or all of the following powers:

(1) To hire any consultants or to undertake any studies of the home he deems appropriate.

(2) To make any repairs, improvements or expenditures to eliminate the conditions specified in the complaint and to direct the method or procedures by which this shall be accomplished.

(3) To hire or discharge any employees including the administrator or manager.

(4) To receive or expend in a reasonable and prudent manner the revenues of the home due on the date of the entry of such judgment and to become due under such judgment.

(5) To continue the business of the home and the care of the residents of the home in all its aspects.

(6) To do all acts necessary or appropriate to conserve the property and promote the health, safety or resident care of the residents in the home.

(7) To exercise such other powers as he deems necessary or appropriate to implement the court order.

d. No provision in this section shall limit the right of any owner to sell or mortgage any home subject to receivership under this act.

L.1977, c. 238, § 7, eff. Sept. 29, 1977.

26:2H-43. Order to remove or remedy conditions in lieu of judgment; bond; failure to comply; hearing; judgment

a. If, after a trial, the court shall determine that the evidence warrants the granting of the relief sought and if the owner or licensee of the home shall apply to the court to be permitted to remove or remedy the conditions specified in the complaint and shall demonstrate the ability to promptly undertake and complete the work required, then the court, in lieu of rendering judgment as provided in this act, may issue an order permitting such person to perform the work in accordance with a time schedule and subject to such conditions, including the posting of a bond as security for the performance of the work, as may be fixed by the court.

b. If, after the issuance of an order pursuant to subsection a. of this section, it shall appear that the person permitted to do the same is not proceeding in accordance with the time schedule or in accordance with the conditions imposed by the court, the plaintiff may apply to the court on notice to those persons who have appeared in the proceeding for a hearing to determine whether judgment should be rendered immediately as provided in subsection c. of this section.

c. If, upon a hearing authorized in subsection b. hereof, the court shall determine the owner or licensee is not proceeding in accordance with the time schedule or with the conditions imposed by the court, the court shall issue a final judgment appointing a receiver as authorized in the act. If the person has posted a bond to secure completion of the work, the security or such part of the security as is necessary may be used by the receiver to remedy the conditions.

L.1977, c. 238, § 8, eff. Sept. 29, 1977.

26:2H-44. Reports and accounts of receiver; filing; inspection; presentation or settlement of accounts

The court shall require the filing, at periodic intervals, of reports of action taken by the receiver and of accounts itemizing the revenues and expenditures. The reports shall be open to inspection to all parties to the case. Upon motion of the court or the receiver or of the owner, or licensee, the court may require a presentation or settlement of the accounts. Notice of a motion for presentation or settlement of such accounts shall be served on the owner, licensee and any party of record who appeared in the proceeding and any party in interest in such revenues and expenditures.

L.1977, c. 238, § 9, eff. Sept. 29, 1977.

26:2H-45. Termination of receivership

The receiver, owner or licensee may make a motion to terminate the receivership on grounds that the conditions complained of have been eliminated or remedied. The court may immediately terminate the receivership, or terminate the receivership subject to such terms as the court feels necessary or appropriate to prevent the condition or conditions complained of from recurring.

L.1977, c. 238, § 10, eff. Sept. 29, 1977.

26:2H-46. Receiver; compensation; bond

The court shall allow from the revenues of the home a reasonable amount of compensation for the expenditures and services of a receiver appointed under the provisions of this act. The receiver so appointed may be required to furnish a bond, the amount and form of which shall be approved by the court. The cost of such bond shall be paid for by the home.

L.1977, c. 238, § 11, eff. Sept. 29, 1977.

26:2H-47. Skilled or intermediate care nursing facility; assistance to residents in application for financial assistance

Every skilled or intermediate care nursing facility in this State shall assist its residents in applying to establish eligibility for medical assistance or other payment mechanisms when their self-pay, private insurance, or medicare capability in respect of payment for nursing home facility care, may become sufficiently depleted to necessitate discharge.

L.1977, c. 387, § 1.

Senate Institutions, Health and Welfare Committee Statement

Senate, No. 272—L.1977, c. 387

PURPOSE AND PROVISIONS

Many patients who have been receiving nursing home services find that when they are no longer able to pay for these services, no arrangements have been made to secure financial assistance for them or to refer them to other sources of care. In order to assist nursing home residents in finding the care they need, this bill gives nursing homes a two-fold responsibility. On the one hand, nursing homes would be required to help residents establish eligibility for programs of financial assistance, such as Medicaid, when their own private resources have been exhausted. Preparatory to this, nursing homes would make an assessment of each resident's financial resources shortly after admission. On the other hand, nursing homes would be required to help residents obtain needed medical care upon discharge from the home. A final provision of the bill makes the Department of Institutions and Agencies responsible for assisting nursing homes in identifying sources of payment and care for residents.

New York

Historical Note

Effective Date. Section effective Sept. 1, 1975, pursuant to L.1975, c. 649, § 9.

Former Sections 2809. Former section 2809 was renumbered 2812.

A prior section 2809 was renumbered 2813.

Library References

Asylums 🔑3.
C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

§ 2810. Residential health care facilities; receivership

1. The owner or owners of any residential health care facility may at any time request the department to take over the operation of such facility by the appointment of a receiver. Upon receiving such a request, the department may, if it deems such action desirable, enter into an agreement with any such owners on the appointment of a receiver to take charge of the facility under whatever conditions as shall be found acceptable by both parties. Receivership commenced in accordance with the provisions of this subdivision shall terminate at such time as is agreed upon by the parties, or at such time as either party notifies the other in writing that he wishes to terminate such receivership.

2. a. As a means of protecting the health, safety and welfare of the patients in a residential health care facility, whenever the commissioner revokes the operating certificate of such a facility he shall apply to the supreme court in the county where the facility is situated for an order directing the owner of the land and/or structure on or in which the facility is located to show cause why the commissioner, or his designee, should not be appointed receiver to take charge of the facility. In those cases where operating certificates have been revoked pursuant to paragraph (a) of subdivision five of section twenty-eight hundred six of this chapter the supreme court shall appoint a receiver who may be the commissioner or his designee. Such application shall contain proof by affidavit that the facility has had its operating certificate revoked. Such order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy thereof and the papers on which it is based on the owner or owners of the land and/or structure on or in which the facility is located. If any such owner cannot with due diligence be served personally within the county where the property is located and within the time fixed in such order, then service may be made on such person by posting a copy thereof in a conspicuous place within the facility in question, and by sending a copy thereof by registered

mail, return receipt requested, to such owner at the last addre[illegible] registered by him with the department, or in the absence of such registration, to the address set forth in the last recorded deed with respect to such facility. Service shall be deemed complete on filing proof of service thereof in the office of the county clerk, or the clerk of the city of New York, as the case may be.

b. On the return of said order to show cause, determination shall have precedence over every other business of the court unless the court shall find that some other pending proceeding, having similar statutory precedence, shall have priority. The court may conduct a hearing at which all interested parties shall have the opportunity to present evidence pertaining to the application. If the court shall find that the facts warrant the granting thereof, then the commissioner, or any person designated by the commissioner, shall be appointed receiver to take charge of the facility, and the court shall determine a fair monthly rental for the facility, and for the furniture, fixtures and movable equipment therein, taking into account all relevant factors, including the condition of such facility, and the condition of such furniture, fixtures and movable equipment, which amount shall, except in the case where the receiver is assuming an existing bona fide arm's length lease, not exceed the amount which would be reimbursable to the facility under the medical assistance program for real property costs and for the costs of furniture, fixtures and movable equipment if each patient in the facility were a recipient of medical assistance. Such rental shall be paid by the receiver to the owner or owners of the facility and to the owner or owners of the furniture, fixtures and movable equipment therein for each month that the receivership remains in effect.

c. Any receiver appointed pursuant to this subdivision shall have all of the powers and duties of a receiver appointed in an action to foreclose a mortgage on real property, together with such additional powers and duties as are herein granted and imposed. The receiver shall with all reasonable speed but, in any case, within eighteen months after the date on which the receivership was ordered provide for the orderly transfer of all patients in the facility to other facilities or make other provisions for their continued safety and health care. During the interim period when such patients must remain in the facility, the receiver may correct or eliminate those deficiencies in the facility that seriously endanger the life, health or safety of such patients provided that such correction or elimination of deficiencies does not include major alterations of the physical structure of the facility. He shall, during this period, operate the facility in such a manner as to guarantee safety and adequate health care for such patients. He shall have the power to let contracts therefor or incur expenses provided that where individual items of repairs, improvements or supplies exceed three thousand dollars, the receiver shall obtain price quotations from at least three reputable sources. The receiver shall not be required to file any bond. He shall collect incoming payments from all sources and apply them to the costs incurred in the performance of his functions as receiver. The receiver shall honor all existing leases, mortgages and chattel mortgages that had previously been undertaken as obligations of the owners or operators of the facility. No security interest in any real or personal property comprising the facility or contained within the facility, or in any fixture of the facility, shall be impaired or diminished in priority by the receiver. The receiver shall compensate the owner or owners of any goods held in inventory for those goods which he uses or causes to be used by reimbursing the costs of such goods, except that no such compensation shall be made for any such goods for which the owners or operators of the facility have already been reimbursed. Neither the receiver nor the department shall engage in any activity that constitutes a confiscation of property without the payment of fair compensation.

d. The receiver shall be entitled to the same fees, commissions and necessary expenses as receivers in actions to foreclose mortgages. The receiver shall be liable only in his official capacity for injury to person and property by reason of conditions of the facility in a case where an owner would have been liable; he shall not have any liability in his personal capacity, except for gross negligence and intentional acts. The personnel and facilities of the department shall be available to the receiver for the purposes of carrying out his duties as receiver and the cost of such services shall be deemed a necessary expense of the receiver.

e. (i) The court shall terminate the receivership only under any of the following circumstances:

(a) eighteen months after the date on which it was ordered;

(b) when the department grants the facility a new operating certificate, whether the structure of the facility or the land on which it is located shall be under the same or different ownership; or

(c) at such time as all of the patients in the facility have been provided alternative modes of health care, either in another facility or otherwise.

(ii) At the time of termination, the receiver shall render a full and complete accounting to the court and shall make disposition of surplus money at the direction of the court.

f. (i) Any person who is served a copy of an order of the [illegible] appointing the receiver shall, upon being notified of the name [illegible] address of the receiver, make all payments for goods supplied [illegible] the facility, or services rendered by the facility, to the receiver. [illegible] receipt shall be given for each such payment, and copies of all [illegible] receipts shall be kept on file by the receiver. The amount [illegible] received shall be deposited by the receiver in a special account which shall also be used for all disbursements made by the receiver.

(ii) Any person refusing or omitting to make such a payment after such service and notice may be sued therefor by the receiver. Such person shall not in such suit dispute the authority of the receiver to incur or order such expenses, or the right of the receiver to have such payments made to him. The receipt of the receiver for any sum paid to him shall, in all suits and proceedings and for every purpose, be as effectual in favor of any person holding the same as actual payment of the amount thereof to the owner or other person or persons who would, but for the provisions of this subdivision, have been entitled to receive the sum so paid. No patient shall be discharged, nor shall any contract or rights be forfeited or impaired, nor any forfeiture or liability be incurred, by reason of any omission to pay any owner, contractor or other person any sum so paid to the receiver.

g. Any other provision of this chapter notwithstanding, the department may, if it deems appropriate, grant to any facility operating or scheduled to operate under a receivership authorized by this subdivision an operating certificate the duration of which shall be limited to the duration of the receivership.

h. No provision contained herein shall be deemed to relieve the owner or any other person of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner or any other person prior to the appointment of any receiver hereunder, nor shall anything contained herein be construed to suspend during the receivership any obligation of the owner or any other person for the payment of taxes or other operating and maintenance expenses of the facility nor of the owner or any other person for the payment of mortgages or liens.

3. The commissioner is authorized to make non-interest bearing payments to receivers appointed pursuant to this section within the amounts made available therefor by the legislature. No such payment shall be made unless the commissioner reasonably anticipates that repayment shall be made prior to or upon termination of the receivership. Any such payment to a receiver shall be made pursuant to a repayment agreement entered into by the receiver with the commissioner which shall specify a time within which full

repayment must be made. Repayments by receivers shall be applied to reimburse any first instance appropriation made for the purposes of this subdivision.

(Added L.1975, c. 649, § 7; amended L.1977, c. 896, § 2; L.1981, c. 609, § 1; L.1981, c. 1021, § 2; L.1984, c. 969, § 7.)

Historical Note

1984 Amendment. Subd. 2, par. b. L.1984, c. 969, § 7, eff. Aug. 6, 1984, in sentence beginning "If the court" inserted "and for the furniture, fixtures and movable equipment therein", "and the condition of such furniture, fixtures and movable equipment," and "and for the costs of furniture, fixtures and movable equipment" and in sentence beginning "Such rental shall" inserted "and to the owner or owners of the furniture, fixtures and movable equipment therein."

Subd. 2, par. c. L.1984, c. 969, § 7, eff. Aug. 6, 1984, provided that an appointed receiver would have to incur price quotations from at least three reputable sources where certain incurred expenses would exceed three thousand dollars.

Subd. 2, par. h. L.1984, c. 969, § 7, eff. Aug. 6, 1984, inserted "or any other person" in three instances.

1981 Amendments. Subd. 2, par. b. L.1981, c. 609, § 1, eff. July 21, 1981, in sentence beginning "If the court" added "except in the case where the receiver is assuming an existing bona fide arm's length lease, not exceed the amount which would be reimbursable to the facility under the medical assistance program for real property costs if each patient in the facility were a recipient of medical assistance", and inserted "Such rental shall".

Subd. 3. L.1981, c. 1021, § 2, added subd. 3.

1977 Amendment. Subd. 2, par. a. L.1977, c. 896, § 2, eff. Aug. 11, 1977, in sentence beginning "As a means" substituted "he shall apply" for "he may apply"; inserted sentence beginning "In those cases"; and in sentence beginning "Such application shall" deleted "and that all judicial appeals available to the owner of the facility have been completed, or the time for taking such appeals has expired" following "operating certificate revoked".

Effective Date of L.1981, c. 1021; Reimbursement for Fees; Expiration of Amendment of Section 2808. Section 4 of L.1981, c. 1021, provided: "This act [amending this section and section 2808] shall take effect immediately [Nov. 6, 1981], provided, however, that the provisions of this act shall be of no force and effect unless and until the federal government agrees to reimburse under titles XVIII and XIX of the federal social security act [42 U.S.C.A. §§ 1395 et seq., 1396 et seq.] the costs of the fee assessed pursuant to section one of this act, and provided further, that section one of this act [amending section 2808] shall remain in full force and effect until December thirty-first, nineteen hundred eighty-three. No facility shall have its reimbursement rate decreased or payment delayed because of this act."

Effective Date. Section effective Sept. 1, 1975, pursuant to L.1975, c. 649, § 9.

Former Section 2810. A former section 2810 was renumbered 2813.

Cross References

Commissions of receivers, see CPLR 8004.

Receivers generally, see CPLR 6401 et seq.

Receivers in actions to foreclose mortgages upon real property, see RPAPL § 1325.

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1. Purpose

1981 amendment to this section requiring that the fair monthly rental for a health care facility in receivership shall not exceed the amount which would be reimbursable to the facility under the medical assistance program for "real property costs" if each patient in the facility were a recipient of medical assistance is intended to keep rent at or below medicaid reimbursement levels so that the receiver may not use funds allocated for operating costs to meet other obligations, thereby reducing services to patients, and operates to limit the fair monthly rental to an amount not greater than that which would have been reimbursable under medicaid guidelines. Schwartzberg v. Axelrod, 1984, 100 A.D.2d 694, 474 N.Y.S.2d 645.

2. Nature of section

This section providing, inter alia, that whenever State Commissioner of Health revokes operating certificate of residential health care facility, he shall apply for order directing owner of land and/or structure to show cause why Commissioner or his designee should not be appointed receiver to take charge of facility, is mandatory and not directory. McCormick v. Axelrod, 1983, 59 N.Y.2d 568, 466 N.Y.S.2d 277, 453 N.E.2d 506.

3. Jurisdiction and power of court

Commissioner of Health, as court-appointed receiver of residential health care facilities was within court's control, furthermore disposition of receivership was also in court's control and not that of receiver. Schwartzberg v. Whal[illegible] 1983, 96 A.D.2d 974, 466 N.Y.S.2d [illegible]

4. Order appointing receiver

Even if order appointing State Health Commissioner the involuntary receiver of two health care facilities had been properly extended, said order would not be found to contravene this section by inhibiting the Commissioner's operation of those facilities "in such a manner as to guarantee safety and adequate health care for [the] patients." Schwartzberg v. Whalen, 1982, 87 A.D.2d 665, 448 N.Y.S.2d 838.

5. Rental of facility—Computation of amount

The ultimate purchase price did not represent the fair market value of the equipment in determining the amount of monthly rental to which the petitioners were entitled under this section for the health care facilities in receivership since, in absence of an appropriate medicaid guideline, the only testimony concerning an appropriate standing to evaluate the lease-purchase payments was a vague reference to a $12,000 per bed ceiling on movable equipment. Schwartzberg v. Axelrod, 1984, 100 A.D.2d 694, 474 N.Y.S.2d 645.

In setting a fair rental value for use of petitioners' health care facilities which were in receivership, petitioners were not entitled to a credit in the sum of $19,405 for nonused telephone system which the receiver removed from the facilities, where the system was not limited to patient care and where there was no approximate medicaid reimbursement guideline. Schwartzberg v. Axelrod, 1984, 100 A.D.2d 694, 474 N.Y.S.2d 645.

Petitioners' aggregate investment credit in two health care facilities which had been placed in receivership was subject to being reduced by the sum of $206,000 in setting a fair monthly rental value for use of those facilities pursuant to a $200 to $300 per bed medicaid ceiling on movable equipment expenses which was in effect during the years petitioners were operating the facilities. Schwartzberg v. Axelrod, 1984, 100 A.D.2d 694, 474 N.Y.S.2d 645.

6. —— Persons entitled to rents

Mortgagee, which was assignee of rents due the owners from operators of residential skilled nursing facility and another related facility which had both been placed into receivership, was entitled to receive the rent due under an existing lease from the receiver from the day the receiver took over. Schwartzberg v. Whalen, 1979, 99 Misc.2d 708, 416 N.Y.S.2d 957.

7. —— Questions for court

"What was necessary and reasonable" under the appropriate medicaid guidelines for lease debt purchase payments or, alternatively, for the purchase price when the lessee acquired title by purchase was to be determined in first instance by the trial court after the parties had presented more concrete evidence on the point and that determining a fair monthly rental value under this section for use of the petitioners' health care facilities and receivership. Schwartzberg v. Axelrod, 1984, 100 A.D.2d 694, 474 N.Y.S.2d 645.

8. Claims by or against receiver

That New York Commissioner of Health had been appointed receiver of nursing home did not so separate Commissioner from his public office that he was not to be viewed and treated, for Eleventh Amendment purposes, as state officer, but where it was likely that funds received in payment for goods and services provided by home had been maintained in special account and separate from state treasury as required by this section, Eleventh Amendment posed no bar to federal jurisdiction over reimbursement claims. U.S. v. DCS Development Corp., D.C.N.Y.1984, 590 F.Supp. 1117.

9. Control of facility funds

Commissioner of Health, who was appointed as receiver of residential skilled nursing facility and health-related facility, had no valid claim to balance, which, on day when he took over as receiver, was on hand in operators' accounts utilized in connection with operation of the facilities, and had no authority to stop payment on checks recently drawn on the accounts. Schwartzberg v. Whalen, 1979, 99 Misc.2d 711, 416 N.Y.S.2d 959.

10. Labor disputes

Question whether a valid agreement to arbitrate prereceivership disputes existed between receiver appointed for health care facility and union representing employees of facility was to be determined by state rather than federal law where petitioner, as designee of court-appointed receiver, the Commissioner of Health, was not an employer within meaning of National Labor Relations Act, 29 U.S.C.A. § 152(2) and the facility was a political subdivision of the state, the Commissioner having complete control over the operations thereof. Greenblatt v. Ottley, 1980, 106 Misc.2d 169, 430 N.Y.S.2d 958.

11. Title to facility

In New York, during receivership pursuant to this section of mortgaged residential health care facility, legal title of the facility remains in the mortgagor until after mortgage foreclosure sale. U.S. v. DCS Development Corp., D.C.N.Y.1984, 590 F.Supp. 1117.

12. Transfer of receivership

Where Commissioner of Health offered no evidence that health, safety and welfare of patients of residential care facilities required continued protection of receiver indefinitely in future, rather than transfer of operations of facility to newly appointed operator, and there was evidence that morale and attitude of employees of facilities in receivership were adversely affected by meetings and contacts made by personnel of hospital to whom Commissioner intended to transfer receivership, special term did not abuse its discretion in narrowly enjoining Commissioner from transferring receivership to another party. Schwartzberg v. Whalen, 1983, 96 A.D.2d 974, 466 N.Y.S.2d 846.

§ 2811. Discounts and splitting fees with medical referral services; prohibited

No hospital or facility delivering health care shall grant or receive a discount to or from any medical referral service or in any manner split fees with a medical referral service.

(Formerly § 2808, added L.1971, c. 776, § 1, renumbered 2811, L.1975, c. 649, § 7.)

Historical Note

Effective Date: Implementation. See section 14 of L.1966, c. 813, set out as a note under section 2850.

Library References

Asylums ⟹1.
C.J.S. Asylums and Institutional Care Facilities §§ 2, 3.

Notes of Decisions

1. Gift of public property

A gift of city-owned real property to a nursing home company created pursuant to this article is prohibited by Const. Art. 8, § 1. 1968, Op.Atty.Gen. (Inf.) Oct. 28.

§ 2862. Supervision and regulation

1. The commissioner may from time to time make, alter, amend and repeal rules and regulations for the supervision, examination, regulation and audit of nursing home companies and for carrying into effect the provisions and purposes of this article, and each company shall submit an annual report of its operations to the commissioner and the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, who may examine and audit the books and records of the company at any time.

2. The commissioner and the department of health shall have power to act for and in behalf of the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, in servicing the nursing home mortgage loans of such agency, and to perform such functions and services in connection with the making, servicing and collection of such loans as shall be requested by such agency.

3. (a) The commissioner and the department of health may, with respect to any nursing home project of which the New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be, has acquired the fee or otherwise, enter into an agreement with said agency subject to the approval of the director of the budget, for the department of health, as provided in paragraph (b) hereof, to operate the said project in a manner consistent with the purposes of this article. In such event, the commissioner, on behalf of the department of health, shall have the power to use any available funds to pay all operating expenses and to comply with all the terms and provisions of the mortgage, as though the mortgage had not been foreclosed, and to comply with the provisions of this article.

(b) Subject to the provisions of the agreement with said agency, the commissioner may contract with any person, firm or corporation which he deems qualified to operate and manage such project and to perform such duties and functions as he may deem necessary.

4. Whenever the commissioner shall be of the opinion that a company is failing or omitting, or is about to fail or omit to do anything required of it by law or by order of the commissioner and is doing or is about to do anything, or permitting anything, or is about to permit anything to be done, contrary to or in violation of law or of any order of the commissioner, or which is improvident or prejudicial to the interest of the public, the lienholders, the shareholders, or the occupants, the commissioner may, in addition to such other remedies as may be available, commence an action or proceeding in the supreme court of the state of New York in the name of the commissioner, for the purpose of having such violations or threatened violations stopped and prevented, and in such action or proceeding, the court may appoint a temporary or permanent receiver or both. Such action or proceeding shall be commenced by a petition to the supreme court, alleging the violation complained of and praying for appropriate relief. It shall thereupon be the duty of the court to specify the time, not exceeding twenty days after service of a copy of the petition, within which the company complained of must answer the petition. In case of any default or after answer the court shall immediately inquire into the facts and circumstances in such manner as the court shall direct in the interest of substantial justice without other or formal pleading. Such other persons or corporations as it shall seem to the court necessary or proper to join as parties in order to make its order or judgment effective, may be joined as parties. The final judgment in any such action or proceeding shall either dismiss the action or proceeding or direct that an order or an injunction, or both, issue, or provide for the appointment of a receiver as prayed for in the petition, or grant such other relief as the court may deem appropriate.

(Added L.1966, c. 813, § 1; amended L.1968, c. 862, § 19; L.1973, c. 392, § 16.)–

Historical Note

1973 Amendment. Subd. 1. L.1973, c. 392, § 16, eff. June 5, 1973, inserted "or the New York state medical care facilities finance agency, as the case may be,".

Subd. 2. L.1973, c. 392, § 16, eff. June 5, 1973, substituted "New York state housing finance agency or the New York state medical care facilities finance agency, as the case may be" for "agency", and "such" for "the" in two instances.

Subd. 3, par. (a). L.1973, c. 392, § 16, eff. June 5, 1973, in sentence beginning "The commissioner and" inserted "or the New York state medical care facilities finance agency, as the case may be,".

1968 Amendment. Subd. 4. L.1968, c. 862, § 19, eff. Sept. 1, 1968, added subd. 4.

Effective Date: Implementat See section 14 of L.1966, c. 813, set as a note under section 2850.

Cross References

Annual report of the New York state housing finance agency, see Private Housing Finance Law § 56.
Injunctions—
  Generally, see CPLR 6301 et seq.
  Against violations of article 28, see section 2801–c.
Liability of certain persons, see section 2808–a.
Proceeding by attorney general for injunctive relief, see section 2897–d.
Residential health care facilities—
  Receivership, see section 2810.
  Reports of, see section 2805–e.

New York Codes, Rules and Regulations

Nursing home—
  Administration, licensure and practice of, see 10 NYCRR Part 96.
  Organization and administration, see 10 NYCRR Part 415.
  Patient services, see 10 NYCRR Part 416.
Nursing home company mortgage loan charges, see 10 NYCRR Part 87.
Reporting information for inspection, see 10 NYCRR Part 412.
Residential health care facility, uniform reporting, see 10 NYCRR Part 450 et seq.

Library References

Asylums ⟹3.
C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

§ 2863. Payment out of earnings of limited-profit nursing home companies

There shall be paid annually out of the earnings of the limited-profit nursing home company, after providing for all taxes, assessments and expenses, a sum for interest on and amortization of the mortgage indebtedness of all mortgages of the company, depreciation charges and reserves if, when and to the extent deemed necessary by the commissioner, plus a dividend of six per centum on outstanding shares and interest not exceeding six per centum on the outstanding debentures of the company; the obligation in respect to such payments shall be cumulative, and any deficiency in interest, amortization, depreciation, reserves, if any, and dividends in any year shall be paid either from any cash surplus derived from earnings remaining in the treasury of such company in excess of the amount necessary to provide such cumulative annual sums or from the first available earnings in subsequent years. If, at the

Okla. Stat. Ann. Tit 63 §1-1931 — 1-1937

Library References

Asylums ⟹5.
C.J.S. Asylums and Institutional Care
Facilities §§ 11, 12.

§ 1-1930. Voluntary closing of facility—Notice—Alternative placement of residents—Relocation assistance

Any owner of a facility licensed under this act shall give ninety (90) days' notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than ten percent (10%) of the residents. Such notice shall be given to the Department, to any resident who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The facility shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives. Where the resident is unable to choose an alternative placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility if needed. Also, the Department may promulgate rules and regulations that establish criteria for the acceleration of the notice requirement if extraordinary circumstances warrant it.

Laws 1980, c. 241, § 30, eff. Oct. 1, 1980.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Asylums ⟹5.
C.J.S. Asylums and Institutional Care
Facilities §§ 11, 12.

§ 1-1931. Monitoring of facility—Appointment of receiver

A. The Department may place an employee or agent to serve as a monitor in a facility or may petition the district court for appointment of a receiver for a facility, or both, when any of the following conditions exist:

1. The facility is operating without a license;

2. The Department has suspended, revoked or refused to renew the existing license of the facility;

3. The facility has closed or has informed the Department that it intends to close and adequate arrangements for relocation of residents have not been made at least thirty (30) days prior to closure; or

4. The Department determines that an emergency exists, whether or not it has initiated revocation or nonrenewal procedures, if because of the unwillingness or inability of the licensee to remedy the emergency the Department believes a monitor or receiver is necessary.

B. In any situation described in subsection A of this section, the Department may place a qualified person to act as monitor in the facility. The monitor shall observe the operation of the facility, assist the facility by advising it on how to comply with the state regulations and shall report periodically to the Department on the operation of the facility.

Laws 1980, c. 241, § 31, eff. Oct. 1, 1980.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Receivers ⇐29(1).
C.J.S. Receivers §§ 30 to 32.

§ 1-1932. Emergencies — Petition — Notice — Hearing — Appointment of receiver

A. Where a resident, a resident's representative or a resident's next of kin believes that an emergency exists, each of them, collectively or separately, may file a verified statement with the Commissioner who shall immediately investigate. If the Commissioner determines that proper cause exists, he shall take whatever steps are necessary to protect the health, welfare and safety of the residents including, if necessary, petitioning the court to place the facility under the control of a receiver to ensure that the residents receive adequate care.

B. The court shall hold a hearing within five (5) days of the filing of the petition. The petition and notice of the hearing shall be served on the owner, administrator or designated agent of the facility and the petition and notice of hearing shall be posted in a conspicuous place in the facility not later than three (3) days before the time specified for the hearing, unless a different time limit is fixed by order of the court. The court shall appoint a receiver for a limited time period, not to exceed one hundred eighty (180) days, which shall automatically terminate the receivership unless extended by the court, if it finds that:

1. The facility is operating without a license;

2. The Department has suspended, revoked or refused to renew the existing license of the facility;

3. The facility is closing or has informed the Department that it intends to close and adequate arrangements for relocation of residents have not been made at least thirty (30) days prior to closure;

4. An emergency exists, whether or not the Department has initiated revocation or nonrenewal procedures, if because of the unwillingness or inability of the licensee to remedy the emergency, the appointment of a receiver is necessary; or

5. It is necessary to ensure that the residents get adequate care in a situation in which the residents' health, welfare and safety are threatened.

C. If a petition filed under this section alleges that the conditions listed in subsection B of this section exist within a facility, the court may set the matter for hearing at the earliest possible time. The petitioner shall notify the licensee, administrator of the facility or registered agent of the licensee more than five (5) days prior to the hearing. Any form of written notice may be used. A receivership shall not be established ex parte by the court unless the Commissioner, under oath, has provided a statement that he has personally determined that there is a life endangering situation. A waiver of the five-day notice requirement may be approved by the court in life endangering situations as determined and confirmed under oath, by the Commissioner.

Laws 1980, c. 241, § 32, eff. Oct. 1, 1980.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Receivers ⇔11.
C.J.S. Receivers §§ 13, 14.

§ 1-1933. Receivers—Persons eligible—List—Powers and duties

A. The court may appoint any qualified person as a receiver, except it shall not appoint any owner or affiliate of the facility which is in receivership as its receiver. The Department shall maintain a list of such persons to operate facilities which the court may consider.

B. The receiver shall make provisions for the continued health, safety and welfare of all residents of the facility.

C. A receiver appointed under this act shall exercise those powers and shall perform those duties set out by the court. These powers and duties may include those generally ascribed to receivers and receiverships and may also include the powers and duties of trustees under the 1978 Bankruptcy Code.[1] The court shall provide for the receiver to have sufficient power and duties to ensure that the residents receive adequate care.

Laws 1980, c. 241, § 33, eff. Oct. 1, 1980.

[1] 11 U.S.C.A. § 101 et seq.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Receivers ⇐48.
C.J.S. Receivers §§ 70, 71.

§ 1-1934. Receivers—Insufficient funds to perform duties—Compensation

A. If funds are insufficient to meet the expenses of performing the powers and duties conferred on the receiver, or if there are insufficient funds on hand to meet those expenses, the Department may reimburse the receiver for those expenses from funds appropriated for its ordinary and contingent expenses by the Legislature.

B. The court shall set the compensation of the receiver, which shall be considered a necessary expense of a receivership.

Laws 1980, c. 241, § 34, eff. Oct. 1, 1980.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.
Lien for payment under this section, see § 1-1937 of this title.
Surplus operating funds, reimbursement of contingency fund, see § 1-1937 of this title.
Termination of receivership, see § 1-1937 of this title.

Library References

Receivers ⇐196.
C.J.S. Receivers §§ 386, 387.

§ 1-1935. Liability of receiver—Bond

A. A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts or breaches of fiduciary duty.

B. The court may require a receiver to post a bond.

Laws 1980, c. 241, § 35, eff. Oct. 1, 1980.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Receivers ⇔212.
C.J.S. Receivers § 409 et seq.

§ 1-1936. Conditional license may be issued to facility in receivership

Other provisions of this act notwithstanding, the Department may issue a conditional license to a facility placed in receivership. The duration of a license issued under this section is limited to the duration of the receivership.

Laws 1980, c. 241, § 36, eff. Oct. 1, 1980.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Asylums ⇔3.
C.J.S. Asylums and Institutional Care
  Facilities §§ 5 to 8.

§ 1-1937. Termination of receivership

A. The court may terminate a receivership:

1. If the time period specified in the order appointing the receiver elapses and is not extended;

2. If the court determines that the receivership is no longer necessary because the conditions which gave rise to the receivership no longer exist; or the Department grants the facility a new license, whether the structure of the facility, the right to operate the facility, or the land on which it is located is under the same or different ownership; or

3. If all of the residents in the facility have been transferred or discharged.

B. 1. Within thirty (30) days after termination, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected, and of the expenses of the receivership.

2. If the operating funds exceed the reasonable expenses of the receivership, the court shall order payment of the surplus to the owner, after reimbursement of funds drawn from the contingency fund provided for in Section 34 of this act.[1] If the operating funds are insufficient to cover the reasonable expenses of the receivership, the owner shall be liable for the deficiency. Payment recovered from the owner shall be used to reimburse the contingency fund for amounts drawn by the receiver under Section 34 of this act.

3. The Department shall have a lien for any payment made under Section 34 of this act upon any beneficial interest, direct or indirect, of any owner in the following property:

a. the building in which the facility is located,

b. any fixtures, equipment or goods used in the operation of the facility,

c. the land on which the facility is located, or

d. the proceeds from any conveyance of property described in subparagraphs a, b or c above, made by the owner within one (1) year prior to the filing of the petition for receivership.

4. The receiver shall, within sixty (60) days after termination of the receivership, file a notice of any lien created under this section. If the lien is on real property, the notice shall be filed with the county clerk. If the lien is on personal property, the lien shall be filed with the Secretary of State. The notice shall specify the name of the person against whom the lien is claimed, the name of the receiver, the dates of the petition for receivership and the termination of receivership, a description of the property involved and the amount claimed. No lien shall exist under this act against any person, on any property, or for any amount not specified in the notice filed under this paragraph.

Laws 1980, c. 241, § 37, eff. Oct. 1, 1980.

[1] Section 1-1934 of this title.

Cross References

Contracts, residents not to be transferred on termination, see § 1-1921 of this title.

Library References

Receivers ⟹60.
C.J.S. Receivers §§ 92 to 96.

PA. Stat. Ann. 35. Supp 1985

§ 448.814. Provider violations

(a) Notice of violations.—Whenever the department shall upon inspection, investigation or complaint find a violation of this chapter or regulations adopted by the department pursuant to this chapter or pursuant to Federal law, it shall give written notice thereof specifying the violation or violations found to the health care provider. Such notice shall require the health care provider to take action or to submit a plan of correction which shall bring the health care facility into compliance with applicable law or regulation within a specified time. The plan of correction must be submitted within 30 days of receipt of the written notice.

(b) Appointment of master.—When the health care provider has failed to bring the facility into compliance within the time so specified, or when the facility has demonstrated a pattern of episodes of noncompliance alternating with compliance over a period of at least two years, such as would convince a reasonable person that any correction of violations would be unlikely to be maintained, the department may petition the court to appoint a master designated as qualified by the department to assume operation of the facility at the facility's expense for a specified period of time or until all violations are corrected and all applicable laws and regulations are complied with, or the department in its discretion may proceed in accordance with this chapter.

1979, July 19, P.L. 130, No. 48, § 814, added 1980, July 12, P.L. 655, No. 136, § 7, imd. effective. As affected 1982, Dec. 20, P.L. 1409, No. 326, art. III, § 318, effective in 60 days.

Repealed in Part

This section is repealed by Act 1980, Oct. 15, P.L. 950, No. 164, § 504 (71 P.S. § 732-504), insofar as it is inconsistent with provisions of said act.

Sections 11(a) and (b) of Act 1980, July 12, P.L. 655, No. 136, provide:

"(a) As to health care facilities defined in chapter 8 of the act subject to licensure or approval pursuant to Article IX or X of the act of June 13, 1967 (P.L. 31, No. 21), known as the "Public Welfare Code", Chapter 8 shall take effect in 120 days and regulations affecting such health care facilities in effect on the date of enactment of this act shall remain effective until replaced or amended in accordance with this act.

"(b) As to health care facilities defined in Chapter 8 of this act not subject to licensure or approval pursuant to Article IX or X of the "Public Welfare Code," Chapter 8 shall take effect in one year."

§ 448.815. Effect of departmental orders

(a) Enforcement.—Orders of the department from which no appeal is taken to the board, and orders of the board from which no timely appeal is taken to the Commonwealth Court, are final orders and may be enforced in court.

(b) Repealed. 1982, Dec. 20, P.L. 1409, No. 326, art. III, § 318 [42 P.S. § 20078], effective in 60 days.

(c) Medical assistance payments.—Orders of the department, to the extent that they are sustained by the board, which fail to renew a license or which suspend or revoke a license, shall likewise revoke or suspend certification of the facility as a medical assistance provider, and no medical assistance payment for services rendered subsequent to the final order shall be made during the pendency of an appeal for the period of revocation or suspension without an order of supersedeas by the Appellate Court.

1979, July 19, P.L. 130, No. 48, § 815, added 1980, July 12, P.L. 655, No. 136, § 7, imd. effective. As affected 1982, Dec. 20, P.L. 1409, No. 326, art. III, § 318, effective in 60 days.

Repealed in Part

This section is repealed by Act 1980, Oct. 15, P.L. 950, No. 164, § 504 (71 P.S. § 732-504), insofar as it is inconsistent with provisions of said act.

Wisconsin

(f) *Term; inspection.* A conditional license shall be issued for a period specified by the department, but in no event for more than one year. The department shall periodically inspect any nursing home operating under a conditional license. If the department finds substantial failure by the nursing home to follow the plan of correction, the conditional license may be revoked as provided under s. 50.03(5). The licensee is entitled to a hearing on the revocation under s. 50.03(5), but the department may rely on facts found in a hearing under par. (e) as grounds for revocation.

(g) *Expiration.* If the department determines that a conditional license shall expire without renewal or replacement of the conditional license by a regular license, the department shall so notify the licensee at least 30 days prior to expiration of the license. The notice shall comply with notice requirements under s. 50.03(5). The licensee is entitled to a hearing under s. 50.03(5) prior to expiration of the license.

Source:

St.1975, § 50.02(3)(4).
L.1977, c. 170, §§ 6, 29, eff. Nov. 22, 1977.
L.1977, c. 272, § 21, eff. April 26, 1978.
L.1979, c. 34, § 842f, eff. July 29, 1979.
L.1981, c. 20, § 885, eff. July 31, 1981.
L.1981, c. 121, §§ 8 to 16, eff. March 3, 1982.
L.1981, c. 317, §§ 30b to 30f, eff. May 1, 1982.
L.1981, c. 391, § 58, eff. June 17, 1982.
1983 Act 27, § 2200(1)(a)2, eff. July 2, 1983.

1981 Legislation:

Laws 1981, c. 121, § 11 repealed subsec. (4)(d), relating to suspension of referrals to nursing homes with certain existing violations.

Administrative Code References

Appeals practice and procedure, see section NHFA 1.01 et seq.

Nursing homes, see section HSS 132.11 et seq.

Notes of Decisions

In general 1
Forfeitures 2

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1. In general

Wisconsin veterans home was not subject to forfeiture provisions of this chapter governing licensing and regulation of nursing homes by the Department of Health and Social Services. Wisconsin Veterans Home v. Division of Nursing Home Forfeiture Appeals (App.1981) 310 N.W.2d 646, 104 Wis.2d 106.

Before payment of settlement is made in resolution of an action against the county, the county board as a whole must approve it. Op.Atty. Gen., Feb. 2, 1981.

2. Forfeitures

A county-operated nursing home that violates a regulation is subject to forfeiture provisions of this section. Lakeland Nursing Home v. Division of Nursing Home Forfeiture Appeals (1984) 348 N.W.2d 523, 118 Wis.2d 686.

Decision by Division of Nursing Home Forfeiture Appeals to impose a $500 forfeiture for county-operated nursing home's class B violation of regulation, arising out of a nurse's aide's attempts to force feed an elderly diabetic patient, was a proper exercise of discretion. Lakeland Nursing Home v. Division of Nursing Home Forfeiture Appeals (1984) 348 N.W.2d 523, 118 Wis.2d 686.

Reasonable interpretation of St.1979, § 227.01 of Administrative Procedure Act defining "agency," and governing parties and procedures for review of agency decisions is that department of administration is "governmental entity" whose decision is sought to be reviewed when forfeiture is assessed against nursing home and is "agency" as that term is used in statute; thus, service of petition for review on department of administration satisfied St.1979, § 227.16 governing parties and procedures for review even though subunit of department of administration had rendered forfeiture decision. Sunnyview Village Inc. v. State Dept. of Administration (1981) 311 N.W.2d 632, 104 Wis.2d 396.

Under this section governing special provisions applying to licensing and regulation of nursing homes, St.1979, § 15.103 governing specified divisions of department of administration and attachment of divisions for limited purposes, while division of nursing home forfeiture appeals is, for purposes of organization of executive branch, a subdivision within department of administration, division of nursing home forfeiture appeals has substantial decision-making autonomy, and department of administration appears to have limited, if any, power, authority, or control over Division's decision-making function as to forfeitures. Id.

50.05. Placement of monitor and appointment of receiver

(1) **Definitions.** In this section:

(a) "Affiliate" means:

1. With respect to a partnership, each partner thereof.

2. With respect to a corporation, each officer, director, principal stockholder and controlling person thereof.

3. With respect to a natural person: any person related in the first degree of kinship to that person; each partnership and each partner thereof of which that person or any affiliate of that person is a partner; and each corporation in which that person or any affiliate of that person is an officer, director, principal stockholder or controlling person.

(b) "Controlling person" means any person who has the ability, directly or indirectly, to control the management or policies of the facility.

(c) "Emergency" means a situation, physical condition or one or more practices, methods or operations which presents imminent danger of death or serious physical or mental harm to residents of the facility.

(d) "Facility" means a nursing home or community-based residential facility.

(e) "Operator" means any person licensed or required to be licensed under this subchapter as the operator of a facility.

(f) "Principal stockholder" of a corporation means any person who, directly or indirectly, beneficially owns, holds or has the power to vote, 10% or more of any class of securities issued by the corporation.

(2) Conditions for placement of a monitor or appointment of a receiver. The department may place a monitor in a facility and may petition for appointment of a receiver for a facility when any of the following conditions exist:

(a) The facility is operating without a license.

(b) The department has suspended, revoked or refused to renew the existing license of the facility.

(c) The department has initiated revocation or nonrenewal procedures and has determined that the lives, health, safety, or welfare of the residents cannot be adequately assured pending a full hearing on license nonrenewal or revocation.

(d) The facility is closing or intends to close and adequate arrangements for relocation of residents have not been made at least 30 days prior to closure.

(e) The department determines that an emergency exists.

(3) Monitor. In any situation described in sub. (2), the department may place a person to act as monitor in the facility. The monitor shall observe operation of the facility, assist the facility by advising it on how to comply with state regulations, and shall submit a written report periodically to the department on the operation of the facility.

(4) Appointment of receiver. The secretary, represented by the department of justice, may apply by verified petition to the circuit court for the county in which the facility is located for an order appointing the secretary or the secretary's designee receiver of the facility. The court shall hold a hearing on the petition within 5 days of the filing of the petition. The petition and notice of the hearing shall be served on the operator, administrator or designated agent of the facility as provided under ch. 801 or shall be posted in a conspicuous place in the facility not later than 3 days before the time specified for the hearing, unless a different period is fixed by order of the court. The court shall appoint a receiver for a * * * specified time period * * * up to 180 days, if it finds that any ground exists which would authorize the appointment of a receiver under sub. (2) and that appointment of a receiver will contribute to the continuity of care or the orderly and safe transfer of residents in the facility. The court may extend the period of receivership in 90-day increments on request.

(5) Emergency procedure. If it appears from the petition filed under sub. (4), or from an affidavit or affidavits filed with the petition, or from testimony of witnesses under oath when the court determines that this is necessary, that there is probable cause to believe that an emergency exists in the facility, the court shall immediately issue the requested order for appointment of a receiver, ex parte and without further hearing.

Notice of the petition and order shall be served on the operator, administrator, or designated agent of the facility as provided under ch. 801 or shall be posted in a conspicuous place in the facility within 24 hours after issuance of the order and a hearing on the petition shall be held within 5 days after notice is served or posted unless the operator consents to a later date. After the hearing, the court may terminate, continue or modify the temporary order.

(6) OBJECTIVE. The receiver shall with all reasonable speed, but in any event by the date receivership ends under sub. (4), provide for the orderly transfer of all residents in the facility to other suitable facilities or make other provisions for their continued health, safety and welfare.

(7) POWERS AND DUTIES OF RECEIVER. A receiver appointed under this chapter:

(a) May exercise those powers and shall perform those duties set out by the court.

(b) Shall operate the facility in such a manner as to assure safety and adequate health care for the residents.

(c) Shall have the same rights to possession of the building in which the facility is located and of all goods and fixtures in the building at the time the petition for receivership is filed as the operator would have had if the receiver had not been appointed. The receiver shall take such action as is reasonably necessary to protect or conserve the assets or property of which the receiver takes possession, or the proceeds of any transfer thereof, and may use them only in the performance of the powers and duties set forth in this section and by order of the court.

(d) May use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the facility at the time the petition for receivership was filed. The receiver shall collect payments for all goods and services provided to residents or others during the period of the receivership, at the same rate of payment as was charged by the operators at the time the petition for receivership was filed, unless a different rate is set by the court.

(e) May correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety or health of residents while they remain in the facility, provided the total cost of correction does not exceed $3,000. The court may order expenditures for this purpose in excess of $3,000 on application from the receiver.

(f) May let contracts and hire agents and employes to carry out the powers and duties created under this section. Competitive bidding requirements under s. 16.75 do not apply to contracts for services or materials let by the receiver.

(g) Except as specified in sub. (9), shall honor all leases, mortgages and secured transactions governing the building in which the facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of the receivership, or which, in the case of a purchase agreement, come due during the period of the receivership.

(h) Shall have full power to direct and manage and to discharge employes of the facility, subject to any contract rights they may have. The receiver shall pay employes at the same rate of compensation, including benefits, that the employes would have received from the operator, except that the receiver shall compensate employes only for time actually worked during the period of receivership and shall not be responsible for reimbursement for vacations or periods of sick leave. The receiver may grant salary increases and fringe benefits to employes of a nursing home, in accord with the nursing home reimbursement formula under s. 49.45(6m). Receivership does not relieve the operator of any obligation to employes not carried out by the receiver.

(i) Shall, if any resident is transferred or discharged, provide for:

1. Transportation of the resident and the resident's belongings and medical records to the place to which the resident is being transferred or discharged.

2. Aid in location of an alternative placement and in discharge planning.

3. If the patient is being transferred, preparation for transfer to mitigate transfer trauma.

(j) Shall, if any resident is to be transferred, permit participation by the resident or the resident's guardian in the selection of the resident's alternative placement.

(k) Shall, unless emergency transfer is necessary, prepare a resident under pars. (i) 2 and (j) by explaining alternative placements, and by providing orientation to the placement chosen by the resident or the resident's guardian.

(*l*) Shall be entitled to and shall take possession of all property or assets of residents which are in the possession of an owner, operator or controlling person of the facility. The receiver shall preserve all property, assets and records of residents of which the receiver takes possession and shall provide for the prompt transfer of the property, assets and records to the alternative placement of any transferred resident.

(8) Payment to receiver. (a) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver for any goods or services provided by the receiver after the date of the order if the person would have been liable for the goods or services as supplied by the operator. The receiver shall give a receipt for each payment and shall keep a copy of each receipt on file. The receiver shall deposit amounts received in a special account and shall use this account for all disbursements.

(b) The receiver may bring an action to enforce the liability created by par. (a). Proof of payment to the receiver is as effective in favor of the person making the payment as payment of the amount to the person who would, but for this subsection, have been entitled to receive the sum so paid.

(c) A resident may not be discharged, nor may any contract or rights be forfeited or impaired, nor may forfeiture or liability be increased, by reason of an omission to pay an owner, operator or other person a sum paid to the receiver.

(9) Avoidance of preexisting leases, mortgages and contracts. (a) A receiver may not be required to honor any lease, mortgage, secured transaction or other wholly or partially executory contract entered into by the owners or operators of the facility if:

1. The person seeking payment under the agreement was an operator or controlling person of the facility or was an affiliate of an operator or controlling person at the time the agreement was made; or

2. The rental, price or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rental, price or rate of interest at the time the contract was entered into.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage or security interest which the receiver is permitted to avoid under par. (a), and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a reasonable rental, price or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on the application within 15 days. The receiver shall send notice of the application to any known owners of the property involved at least 10 days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or for possession of the goods or real estate subject to the lease or mortgage involved by any person who received such notice, but the payment does not relieve the owner or operator of the facility of any liability for the difference between the amount paid by the receiver and the amount due under the original lease or mortgage involved.

(10) Contingency fund. If funds collected under subs. (7) and (8) are insufficient to meet the expenses of performing the powers and duties conferred on the receiver by this section, or if there are insufficient funds on hand to meet those expenses, the department may draw from the supplemental * * * funds created under s. 20.435(1)(dm) and * * *

(4)(dm) to pay those expenses. Operating funds collected under this section and not applied to the expenses of the receivership shall be used to reimburse the fund for advances made under this section.

(11) Compensation of receiver. The court shall set the compensation of the receiver, which will be considered a necessary expense of a receivership.

(12) Liability of receiver; status as public employe. (a) In any action or special proceeding brought against a receiver in the receiver's official capacity for acts committed while carrying out the powers and duties created under this section, the receiver shall be considered a public employe for purposes of s. 895.46.

(b) A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts or breach of fiduciary duty.

(c) A receiver may not be required to post any bond.

(13) Licensing of facility under receivership. Other provisions of this chapter notwithstanding, the department may issue a license to a facility placed in receivership under this section. The duration of a license issued under this section is limited to the duration of the receivership.

(14) Termination of receivership. The court may terminate a receivership:

(a) If the time period specified in the order appointing the receiver elapses;

(b) If the department grants the facility a new license, whether the structure of the facility, the right to operate the facility, or the land on which it is located is under the same or different ownership; or

(c) If all of the residents in the facility have been provided alternative modes of health care, either in another facility or otherwise.

(15) Accounting; lien for expenses. (a) Within 30 days after termination, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected under this section and of the expenses of the receivership.

(b) If the operating funds collected by the receiver under subs. (7) and (8) exceed the reasonable expenses of the receivership, the court shall order payment of the surplus to the operator, after reimbursement of funds drawn from the contingency fund under sub. (10). If the operating funds are insufficient to cover the reasonable expenses of the receivership, the operator shall be liable for the deficiency. The operator may apply to the court to determine the reasonableness of any expense of the receivership. The operator shall not be responsible for expenses in excess of what the court finds to be reasonable. Payment recovered from the operator shall be used to reimburse the contingency fund for amounts drawn by the receiver under sub. (10).

(c) The department shall have a lien for any deficiency under par. (b) upon any beneficial interest, direct or indirect, of any operator or controlling person in the following property:

1. The building in which the facility is located.

2. The land on which the facility is located.

3. Any fixtures, equipment or goods used in the operation of the facility.

4. The proceeds from any conveyance of property described in subd. 1, 2 or 3, made by the operator or controlling person within one year prior to the filing of the petition for receivership.

(d) The lien provided by this subsection is prior to any lien or other interest which originates subsequent to the filing of a petition for receivership under this section, except for a construction or mechanic's lien arising out of work performed with the express consent of the receiver.

(e) The clerk of the circuit court for the county in which the facility is located shall record the filing of the petition for receivership in the lien docket kept under * * * s. 779.07 opposite the names of the operators and controlling persons named in the petition.

(f) The receiver shall, within 60 days after termination of the receivership, file a notice of any lien created under this subsection. No action on a lien created under this subsection may be brought more than 2 years after the date of filing. If the lien is on real property, the notice shall be filed with the clerk of circuit court of the county in which the facility is located and entered on the lien docket kept under s. 779.07. If the lien is on personal property, the lien shall be filed with the secretary of state. The secretary of state shall place the lien on personal property in the same file as financing statements are filed under ss. 409.401 and 409.402. The notice shall specify the name of the person against whom the lien is claimed, the name of the receiver, the dates of the petition for receivership and the termination of receivership, a description of the property involved and the amount claimed. No lien shall exist under this section against any person, on any property, or for any amount not specified in the notice filed under this paragraph. To the extent applicable, ch. 846 controls the foreclosure of liens under this subsection that attach to real property.

(16) Obligations of owners. Nothing in this section shall be deemed to relieve any owner, operator or controlling person of a facility placed in receivership of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner, operator or controlling person prior to the appointment of a receiver under this section, nor shall anything contained in this section be construed to suspend during the receivership any obligation of the owner, operator or controlling person for payment of taxes or other operating and maintenance expenses of the facility nor of the owner, operator or controlling person or any other person for the payment of mortgages or liens. No owner may be held professionally liable for acts or omissions of the receiver or the receiver's employes during the term of the receivership.

Source:
L.1977, c. 112, § 2, eff. Oct. 25, 1977.
L.1979, c. 32, § 92(9), eff. July 20, 1979.
L.1979, c. 34, § 842m, eff. July 29, 1979.
L.1981, c. 121, § 17, eff. March 3, 1982.
1983 Act 27, § 2202(20)(b), eff. July 2, 1983.

Library References
Asylums ⇐3.
C.J.S. Asylums § 5.

50.053. Informal conference

The department may hold an informal conference with the parties to any contested action under this subchapter to resolve any or all issues prior to formal hearing. Unless any party to the contested case objects, the department may delay the commencement of the formal hearing in order to hold the informal conference.

Source:
L.1977, c. 170, § 30, eff. Nov. 22, 1977.

Library References
Asylums ⇐3.
C.J.S. Asylums § 5.

50.07. Prohibited acts

(1) No person may:

(a) Intentionally fail to correct or interfere with the correction of a class "A" or class "B" violation within the time specified on the notice of violation or approved plan of correction under s. 50.04 as the maximum period given for correction, unless an extension is granted and the corrections are made before expiration of extension.

(b) Intentionally prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the department in the investigation and enforcement of any provision of this subchapter.

(c) Intentionally prevent or attempt to prevent any such representative from examining any relevant books or records in the conduct of official duties under this subchapter.